RESTORING HEALTH CARE TO THE HANDS OF THE PEOPLE

Proceedings of Seminars Sponsored by
BUKLURAN PARA SA KALUSUGAN
NG SAMBAYANAN (BUKAS)

Published by HAIN

RESTORING HEALTH CARE TO THE HANDS OF THE PEOPLE

Proceedings of a Series of Symposia on
Health Policy Development
Sponsored by
Bukluran para sa Kalusugan ng Sambayanan (BUKAS)
[Task Force People's Health]
March - May 1986

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Health Action Information Network (HAIN)
1987

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ISBN 971-8508-02-3

Cover Photo: Jun Cañete
Cover Design: Ed Reyes

ACKNOWLEDGEMENTS

Dean Fernando Sanchez and the University of the East College of Medicine for allowing the use of their auditorium for the symposia;

Maria Mangahas for helping to cover the symposia and James Hammond for proof-reading;

ICCO for supporting the initial printing of proceedings;

Medico International for supporting the final compilation of the proceedings and publication of this book.

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FOREWORD

Health, Development and Democracy

M. L. Tan

Malaria in New York. Tuberculosis in London. Historical accounts of living conditions in the United States and European countries during the 19th and early 20th century show striking parallels with the problems that we confront today in the Philippines and other Third World countries.

It would be over-simplistic to dismiss this crisis in health care as inevitable. One interpretation is that our health problems are typical of "tropical" countries; yet, history shows that so-called tropical diseases were also widespread in temperate countries. Malaria, for instance, was widespread in New York's Richmond, Queens and the Bronx in the early 1900s. Tuberculosis raged mercilessly in the boroughs of London throughout the Industrial Revolution.

An alternative interpretation is that such health problems are unavoidable in the process of modernization, that the "transition" to urbanization is always associated with congested slums and a breakdown of social services. New York in the early 1900s in fact had infant mortality rates higher than those of Calcutta or Bombay today. Epidemics of summer diarrhea, exacerbated by adulterated milk, killed thousands of small children in New York and London in the late 19th and early 20th century.

On the other hand, we also witness the dramatic alternatives that have emerged in other "transitional" societies. The People's Republic of China was able to drastically reduce the incidence of many communicable diseases after their revolution in 1949. Nicaragua, the

second poorest country in Central America (after Haiti), was able to reduce its infant mortality rate from 120/1,000 live births to about 80/1,000 live births within four years after its 1979 revolution.

The difference is to be found in political will, a somewhat strident term that could also be described as political caring, the ability to recognize that disease is caused not just by "germs", the natural environment, the weather, or industrialization, but also by unjust human structures and relationships. Caring enough means a confrontation with institutionalized violence and pathogenic socio-political structures, and the building of a collective will to create a grassroots-based movement to change the status quo.

In the Philippines, the potential strength of "people's power" was manifested in February 1986, with the ouster of the Marcos dictatorship. But this people's power has since slipped into complacency, an unwillingness to face realities, much less to become involved in the difficult processes needed for the long-overdue restructuring of society. Segments of the political leadership, many of whom are from the still deeply entrenched economic elite, are moving too slowly on reforms.

In this book, we present a compilation of papers that were prepared shortly after the February uprising. It was a response from non-governmental health organizations that had long been active in fighting the Marcos dictatorship. If the papers were prepared so quickly, it was because so much work had already been done in identifying the problems and its causes.

The difficult part was formulating the alternatives and suggestions for reform. The ad-hoc Task Force People's Health had drawn in diverse groups anxious to start working together under the new political dispensation. Proposed reforms were wide in range, and there were disagreements on some points, but the general consensus, reflective of the spirit of the period, was that health care had to be restored to the hands of the people.

"The people" has an anonymous and amorphous ring to it, and could lapse into a mechanical connotation – much like "people power" The transformation of "the people" into active human beings in control of their lives must parallel the transformation of "people power" into "people's power". This certainly was to be found in the series of consultations on Health Policy and Development sponsored by the Task Force People's Health: active dialogue, debates. The papers, and the discussions, raised many new questions, for it brought together not just community-based organizations but also school administrators, representatives of mainstream medical groups, hospital managers and workers, businessmen from the drug industry.

The Manifesto for People's Health synthesized divergent views, laying a more concrete blueprint for action programs to meet the health. crisis. But, beyond coping with the crisis, a longer term vision had to come into focus. The Task Force People's Health became the Bukluran para sa Kalusugan ng Sambayanan, a coalition to promote public health.

Evolving from its initially academic nature, the group has since adopted an advocacy role, lobbying for the recommendations made in the Manifesto. The group's acronym, BUKAS even went through a debate in a general assembly Was it to be "bukas" (tomorrow) or "buk ás"(open). The latter interpretation won out. The starving children and the medical indigents could not wait for "tomorrow", it was argued. Thus, an affirmation of the urgency of the situation was adopted, with a significant recognition of the democratic imperative, an openness to new ideas, however heretical and radical. For generally conservative health professionals to have accepted this was, to use current popular jargon, a miracle in itself.

One of BUKÁS' first projects was to join in a multisectoral campaign to have the new government increase the national budget for social services. It supported the requests of the ministries (now departments) of health and education for larger allocations. In the end, the approved budget missed the targets, as debt service and the military continued to take the lion's share of 50% of the total budget, literally leaving crumbs for social services. The 1987 budget for the health department, slightly over ₱4 billion, was less than half of what had been requested, and amounts to only about 0.7% of the current Gross National Product, still way below the World Health Organization's recommendation of 5% if the goal of "Health for All by the Year 2000" is to be achieved. The campaign was BUKAS' first encounter with Realpolitik under the new government, and a rude reminder that so much of the oppressive structures remain intact.

There have been minor victories, and signs of possible change. The new health department is more receptive. Consultations with non-governmental organizations (NGOs) have been conducted on issues such as the implementation of the Rural Health Practice Program (RHPP) and the development of national drug policies.

The appointment of one of BUKÁS' Executive Council members, Minda Luz Quesada to the Constitutional Commission opened new opportunities for the inclusion of the health sector's recommendations in the new Constitution, including the recognition of health as a basic right. Several passages in the Constitution provide the mandate for the State to expand its services for the disadvantaged and marginalized sectors of society.

But much more has to be done. Health is a right that can be attained only through meeting other basic rights. The economic and political crisis

has not ended. Many of the provisions of the new Constitution will have to be translated into laws by the Congress to be elected in May 1987. Implementation of whatever laws that might be passed will require even greater efforts.

How long can our people wait? The government recently released figures showing that moderate and severe under-nutrition among Filipino pre-schoolers increased after the onset of the current economic crisis in 1983. According to the figures, the prevalence rate of severely (third-degree) and moderately (second degree) malnourished pre-schoolers increased from 18% in 1984 to 20% in 1986. In at least 10 provinces, mostly in the Visayas and Mindanao, the figure exceeded 25%.

Preliminary figures from the Department of Health likewise show staggering increases in the morbidity rates of the leading diseases, increases which cannot be explained simply in terms of better reporting from the field:

Leading Causes of Morbidity (Rates/100,000)		
	1979-1983 (Average)	**1984**
1. Chronic Obstructive Pulmonary Diseases (Bronchitis, Emphysema, Asthma)	527.2	1039.7
2. Gastroenteritis and colitis (Diarrheas)	465.3	962.7
3. Influenza	442.1	783.4
4. Pneumonias	242.2	337.7
5. Tuberculosis (all forms)	222.5	264.1
6. Malaria	85.0	207.4
7. Dysentery, all forms	65.9	n.a.
8. Measles	65.6	126.5
9. Malignant neoplasms	51.2	50.6
10. Whooping cough	38.3	n.a.

SOURCES: Average for 1979-1983 computed from figures in *Philippine Health Statistics,* Health Intelligence Service, Ministry of Health. Figures for 1984 computed from absolute numbers given in *Evaluation of the Strategy for Health for All by the Year 2000,* Vol. 7: Western Pacific Region, p. 105, based on an official estimated population of 53.1 million.

The mortality figures do not show dramatic increases, but are not any more comforting given the stagnation in rates:

Leading Causes of Mortality (Rates/100,000)		
	1979-1983 (Average)	**1984**
1. Pneumonias	93.8	89.3
2. Diseases of the heart	65.6	61.0
3. Tuberculosis (all forms)	57.2	52.9
4. Diseases of the vascular system	44.9	39.6
5. Malignant neoplasms	33.1	30.3
6. Gastro-enteritis and colitis (diarrheas)	30.1	27.8
7. Accidents	17.0	16.8
8. Avitaminosis and nutritional deficiencies	14.5	13.4
9. Measles	13.7	9.8
10. Chronic obstructive pulmonary diseases	12.2	n.a.

SOURCES: Average for 1979-1983 computed from figures in *Philippine Health Statistics,* Health Intelligence Service, Ministry of Health. Figures for 1984 computed from absolute numbers given in *Evaluation of the Strategy for Health for All by the Year 2000,* Vol. 7: Western Pacific Region, p. 105, based on an official estimated population of 53.1 million.

So much depends on economic recovery; but this will not be easy to achieve. Conservative estimates of how much the Marcos-Romualdez clan looted run to about US$10 billion, equivalent to two years of the national government budget.

And a more pressing question is this: who should be the most immediate beneficiaries of any economic recovery program? Statistics from the National Census and Statistics Office show that in 1971, about 50% of Filipino households had incomes below the poverty threshold level. By 1985, the figure was 60%. The poverty threshold level was set at ₱2,376 (US$116) per month.

Official figures show that income inequities worsened over the last decade, so that by 1985, the richest 10% of the population accounted for 37% of total income while the poorest 10% had to contend with 2% of the total. With half of the labor force still unemployed or underemployed, poverty remains the greatest national scandal.

Economists know very well that it may take two or three years before we even feel the full effects of an economic crisis on the health situation. And, certainly it will take time to reverse the adverse effects. It is a race against time, and we cannot afford more mistakes.

BUKAS does not have all the answers. But there can be no arguments over the need to restructure the health care system, away from an elitist "delivery" system to one which is based on the power of people, and of communities, to transform the situation. Community-based health programs have proven that such changes can take place, although only at a micro-level. The emergence of new health organizations to tackle issues of health policy and reforms in various fields such as occupational safety, human rights, drug policy and many other public interest concerns underscores the need to educate and mobilize all sectors of Philippine society to build an alternative health care system.

It is said that the February uprising was a political revolution, and that a social revolution must follow. But there are questions even as to the extent of the political transformation that has taken place. The Marcos dictatorship has been overthrown, and formal political rights have been restored, but so much of the authoritarian legacy – nurtured not just by the Marcos era but by the long period of colonial occupation – remains with us. The health sector, for all its trappings of service, bears many similarities to other authoritarian structures in churches and the military with its rigid hierarchies and elitism.

The democratization of health – restoring the responsibility of health care to the hands of the people – is an imperative. But such programs as primary health care should not be used as an excuse for more neglect on the pretext that the poor should be "self-reliant" People have to be empowered to take more responsibility. A redistribution of economic resources must take place together with a redistribution of political power. "People's participation" is meaningless if it remains limited to the implementation of decisions made "by the top" It remains meaningless when attempts to speak out are silenced by bullets. It remains meaningless if people continue to be subjected to disinformation, offered illusory choices and symptomatic remedies.

The wounds and scars remain, memories of a continuing past which will not disappear with ritual exorcisms, religious or secular. Amid the chanting crowds and the dancing in the streets, we must not forget that we are only beginning to set the economic and social foundations for an alternative health care system. And even at this point, we find that the few gains achieved so far are already being eroded with the resurgence of anti-democratic and politically repressive forces that threaten to plunge us back into the dark.

CHAPTER 1

The State of the Nation's Health

Michael L. Tan

I. INTRODUCTION

The choice of the title, "State of the Nation's Health" was intentional, for in discussing the health situation of a country, we are essentially discussing the health of the nation itself. The health system is a microcosm, reflecting the strengths and deficiencies, achievements and failures, of the society in which it is embedded.

For the non-governmental groups, our interest in analyzing the health situation and the health care system in the Philippines dates back to the 1970s, where concerned groups felt that to be able to change the health care system, one had to dissect it, and to understand how it worked. The research efforts have been intensified in the last three years, particularly after the economic crisis began, as we felt the need to keep a closer watch over the "patient" The efforts have paid off in the sense that we have a reasonable collection of facts and figures for analysis.

In this paper, we present some facts and figures to provide a broad overview of the current health situation. An analysis is also presented to demonstrate the many factors that interact in the shaping of health care systems. In a sense, this paper serves as a long introduction to the more detailed papers that will be presented in the weeks to come, focusing on specific issues and problems, and presenting some of the alternatives that are envisioned.

II. THE HEALTH SITUATION

Before wading through the facts and figures, we should be aware that despite what seems to be a wealth of data, we do have missing gaps in the information. It was extremely difficult to obtain reliable statistics during the Marcos era for various reasons.

For instance, there was a tremendous lag in the production of the annual *Philippine Health Statistics* by the Ministry of Health's Health Intelligence Service. In 1984, for instance, we only had access to the 1979 figures. The lag was allegedly due to lack of funds to print the yearbooks. To the credit of the Health Intelligence Service's present director, efforts have been made to overcome this lag. Last month, we were able to get the yearbooks for 1980, 1981 and 1982, and just yesterday, we got the 1983 edition. The *Philippine Health Statistics* has its limitations, mainly because it relies on figures reported from the field, and there is reason to believe that there is under-reporting for births, deaths and the incidence of diseases. Despite these limitations, the yearbooks are the only source for nationwide health statistics and are still useful for a macro-analysis.

Even greater caution should be exerted in interpreting figures related to nutritional status. There is reason to believe that these statistics were to some extent doctored because of its politically volatile nature.

If the reports about statistical manipulation are true, and this has come from "insiders" working in nutrition agencies, then this itself is one indictment against the previous regime.

Working with what we have, we can report on some of the trends that have emerged in the last 20 years, with greater emphasis on the last decade. This time frame corresponds to the Marcos era stating in 1965, through the martial law years (1972-1981) and the so-called normalization period which ended with Marcos' ouster. Many of the figures given are averages since it may be misleading to rely on particular data for one year alone. With a time perspective, we can give a more accurate evaluation of the health status of Filipinos. Table 1 gives morbidity and mortality averages from 1966 to 1983.

TABLE 1

AVERAGE MORBIDITY AND MORTALITY RATES FOR SELECTED NOTIFIABLE DISEASES IN THE PHILIPPINES (1966-1983)
RATES/100,000

	1966–1970	1971–1975	1976–1980	1981–1983
PNEUMONIAS				
Morbidity	221.1	232.4	250.1	232.0
Mortality	118.1	112.8	102.4	90.0
TUBERCULOSIS				
Morbidity	369.7	342.5	260.6	215.5
Mortality	81.7	71.9	65.0	55.3
GASTRO-ENTERITIS & COLITIS				
Morbidity	574.3	555.1	466.2	482.5
Mortality	43.3	37.1	34.8	28.9
MEASLES				
Morbidity	60.4	61.5	60.2	69.9
Mortality	5.6	8.6	11.7	15.3
HEPATITIS				
Morbidity	9.8	12.7	17.3	18.7
Mortality	1.1	1.2	1.7	1.4
MALARIA				
Morbidity	86.7	69.1	75.2	91.6
Mortality	2.6	2.0	2.1	2.1
DYSENTERIES				
Morbidity	49.4	54.8	54.9	70.6
Mortality	3.3	1.8	2.3	2.9
TYPHOID				
Morbidity	2.9	6.9	6.6	9.8
Mortality	0.8	1.3	1.4	1.3

WHOOPING COUGH				
Morbidity	63.0	60.2	46.1	34.5
Mortality	0.4	0.1	0.2	0.1
TETANUS				
Morbidity	11.7	11.1	9.0	5.0
Mortality	10.0	9.2	6.0	1.8
GONOCOCCAL INFECTIONS				
Morbidity	23.5	29.4	19.1	22.2
Mortality	0.0	0.0	0.0	0.0

MORBIDITY

In terms of illness patterns, we find that the leading causes are mainly communicable diseases, both preventable and curable. There have been minimal changes in the last decade: the top ten have remained the same, changing only in their ranks. Significant reductions have been reported for the incidence of influenza, tuberculosis and whooping cough, but at the same time, there have been alarming increases for chronic obstructive pulmonary diseases, malaria, dysenteries and malignant neoplasms. (Table 2)

TABLE 2

LEADING CAUSES OF MORBIDITY
Average Rates (1979-1983)

	RATE/100,000
1. Chronic obstructive pulmonary diseases (Bronchitis, emphysema, asthma)	527.2
2. Gastro-enteritis and colitis (diarrheas)	465.3
3. Influenza	442.1
4. Pneumonias	242.2
5. Tuberculosis, all forms	222.5
6. Malaria	85.0
7. Dysentery, all forms	65.9
8. Measles	65.6
9. Malignant neoplasms (cancers)	51.2
10. Whooping cough	38.3

Morbidity figures for notifiable diseases from 1966 to 1983 reveal other significant facts in terms of diseases that are becoming greater public health problems: [1]

*The incidence of measles has increased, particularly in the 1980s. The average morbidity rate from 1965 to 1979 was 60.7 per 100,000. From 1980 to 1983, the average was 69.9 per 100,000.

*The incidence of infectious hepatitis has almost doubled. The average rate for the years 1966 to 1970 was 9.8 per 100,000, compared with 18.7 per 100,000 for the years 1981 to 1983.

*The average morbidity rate for malaria dropped from 86.7 per 100,000 for the years 1966 to 1970 to 69.1 for 1971 to 1975, but then began to increase again for the last decade. The average rate for the years 1980 to 1983 was 91.6 per 100,000. In fact, the reported rate for 1983 of 105.9 per 100,000 is the highest since 1965.

*The figures for dysenteries and typhoid have showed a steady increase from 1965 onwards. Figures for 1982 and 1983 are again the highest since 1965.

It must be remembered that chronic ailments are not well reported, but a national survey in 1981 by the health ministry revealed a high incidence of problems such as intestinal parasitism, inflammatory diseases of the eye, hypertension, peptic ulcers, gastritis and duodenitis, arthritis and spondylitis, and various skin diseases. High rates were also reported for physical disabilities such as deafness, blindness and mutism. Some of these disabilities are themselves the sequelae of diseases, particularly those incurred in childhood. [2]

MORTALITY

The leading causes of death in the country are again main communicable diseases. (Table 3) While communicable diseases now account for only about a third of total deaths, as compared with 40 percent in the late 1970s, these deaths should still be considered as needless since the diseases are both preventable and curable. [3]

TABLE 3

LEADING CAUSES OF MORTALITY
Average Rates (1979-1983)

	RATES/100,000
1. Pneumonias	93.8
2. Diseases of the heart	65.6
3. Tuberculosis, all forms	57.2
4. Diseases of the vascular system	44.9
5. Malignant neoplasms (cancers)	33.1
6. Gastro-enteritis and colitis (diarrheas)	30.1
7. Accidents	17.0
8. Avitaminosis and nutritional deficiencies	14.5
9. Measles	13.7
10. Chronic obstructive pulmonary diseases (Bronchitis, emphysema, asthma)	12.2

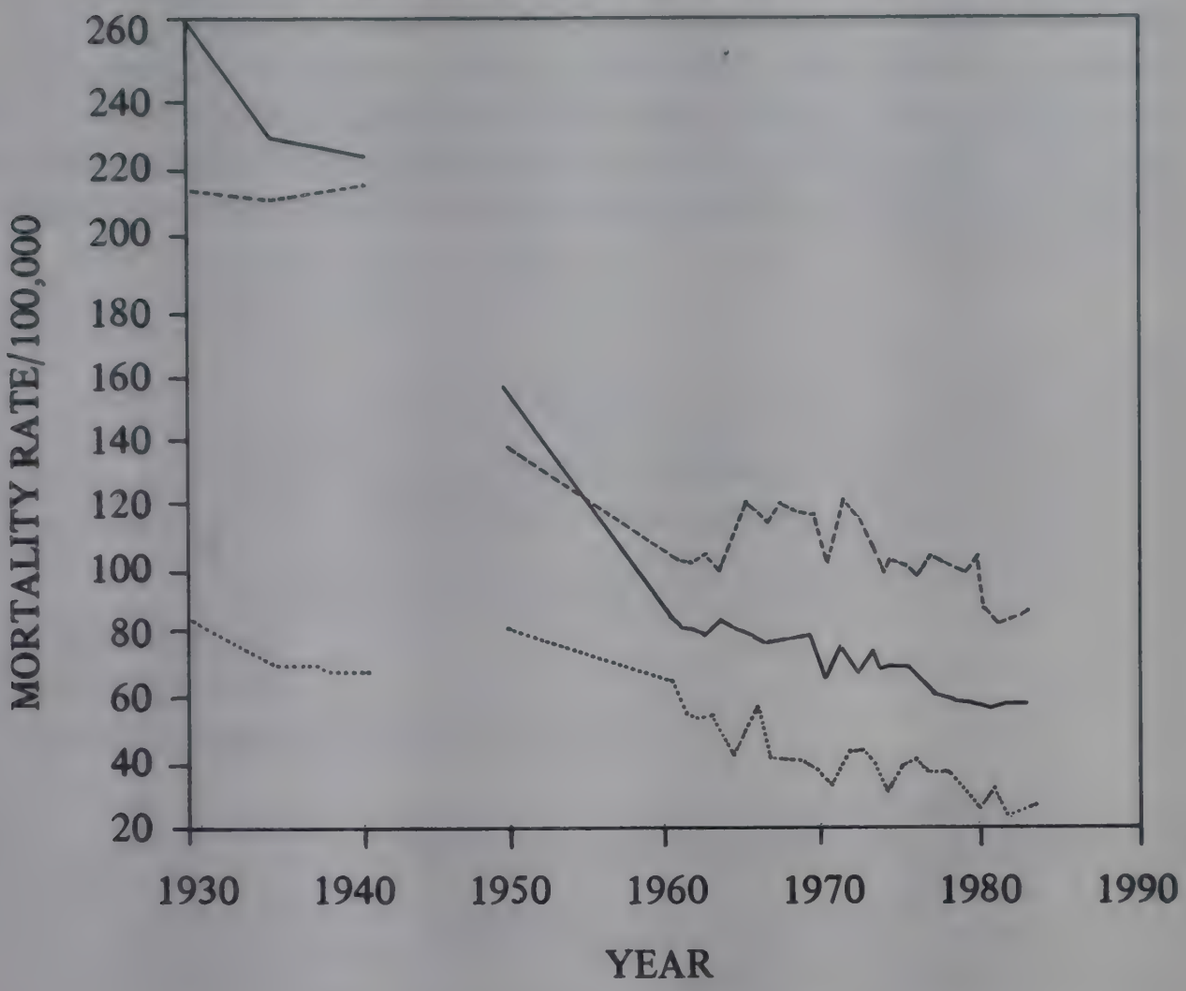
Looking again at trends, the top ten causes of deaths have remained the same in the last decade, with changes only in ranks. There have been declines in the deaths due to chronic obstructive pulmonary diseases, accidents and avitaminosis and nutritional deficiencies while increases are noted for measles and diseases of the heart and the vascular system.

It should be noted that while cardiovascular diseases are associated with industrialized countries, increases can also occur, as they are doing now, in the Third World not necessarily as a sign of development. For instance, the relationship between poverty, stress and hypertension is becoming well established. The control of rheumatic heart diseases, definitively a "social disease", has remained stagnant as shown by the death rates, over the last decade. [4]

For a longer time perspective, let us look at a graph (Fig. 1) showing the mortality rates for pneumonias, tuberculosis and gastro-enteritis. We find here that the greatest gains were actually made in the pre-war era and in the early years of the Republic, followed by a stagnation in the last two decades. Concretely, in terms of the death rates due to tuberculosis, the National Institute of Tuberculosis observes that the annual decline was 3.5 percent from 1940 to 1960, and only 1.5 percent in the last two decades. [5]

FIGURE 1

MORTALITY RATES
PNEUMONIAS, TB, GASTROENTERITIS



---- PNEUMONIAS — TUBERCULOSIS ..... GASTRO-ENTERITIS

INFANT MORTALITY

For a better perspective on the health situation, let us look briefly at infant mortality. Incidentally, there is still no official infant mortality rate, even within the ministry of health. The Health Intelligence Service, for instance, gave an IMR of 42 per 1000 live births for 1983, but the planning division gives a figure of 58 for 1985. The Population Reference Bureau in Washington cites a figure of 65 and former minister Estefania Aldaba-Lim says that independent studies, yet unpublished, give an even higher figure than that of the Population Reference Bureau.

Even if we were to use a figure of 60, this translates to a considerable number of innocent deaths. This means that 6 percent of the infants born this year will die before the age of 1. Projecting further, we would have about 100,000 Filipino infants dying this year.

The sad fact is that the leading causes of infant mortality are again, for the most part, preventable and curable. (Table 4) Respiratory and gastro-intestinal diseases form the bulk of illnesses that claim infant lives, followed by nutritional deficiencies. These infant killers should not be looked at as separate entities, for many of them interrelate, forming a vicious web. The death rates for measles, for instance, have actually increased five-fold, comparing the averages for 1965-1970 and that for 1980-1983. And it is well known that malnutrition aggravates measles, the child often succumbing to complications such as pneumonias and diarrheas.

TABLE 4

LEADING CAUSES OF INFANT MORTALITY
Average Rates (1979-1983)

	RATES/1000 LIVE BIRTHS
1. Pneumonias	11.1
2. Respiratory conditions of the newborn and fetus	5.8
3. Gastro-enteritis and colitis (diarrheas)	4.2
4. Congenital anomalies	2.1
5. Avitaminosis and other nutritional deficiencies	2.0
6. Birth injury and difficult labor	1.4
7. Measles	1.2
8. Chronic obstructive pulmonary diseases (Bronchitis, emphysema, asthma)	1.0
9. Acute respiratory infections	0.9
10. Meningitis	0.6

The continuing high rates of infant and child mortality should also be studied in the context of maternal illnesses and deaths. The maternal mortality rate was estimated at 0.8 per 1000 live births for 1985, caused by a "triad' which has remained unchanged over the last 20 years: hemorrhages, hypertension and complications due to infectious diseases. Most of these deaths could have been prevented through proper pre-natal services.

NUTRITION

As mentioned earlier, the figures for nutrition should be taken cautiously. Despite the suspicions that the figures have been doctored, all the surveys conducted in the last 10 years still show that 70 percent of Filipino pre-schoolers are undernourished. The differences are in the figures for the degree of under-nutrition. Those who have followed the statistics know that Imelda Marcos used to crow about having reduced the rate of third-degree or severe under-nutrition from 3% to 1% within 2 years, a statistical improbability unless, to use some black humor, the severely under-nourished children all died out.

For the Filipino population as a whole, it is interesting that the NEDA Statistical Yearbooks have generally printed available food supply, which show steady increases over the last decade. What they do not print is actual food consumption, and figures from the Ministry of Agriculture show that this has been dropping, an ironical situation when one considers the increasing available food supply.

HEALTH FACILITIES & MANPOWER

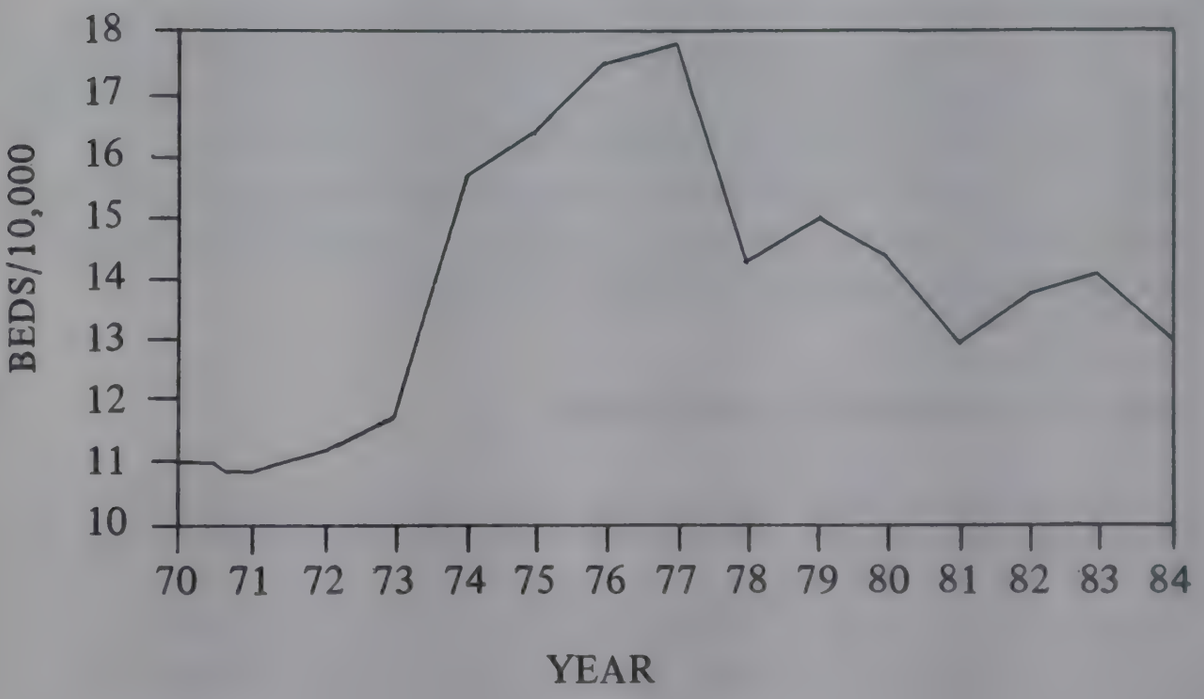
People often equate health care with hospitals, which should not be the case. But even if we were to limit ourselves to that level of health care, we find that the number of available hospital beds in the country increased in the 1970s, and then started to drop. (Fig. 2) The decrease is due to reductions in both the government and private hospitals, although for different reasons. For the private hospitals, it was the economic crisis that forced many to shut down. For government hospitals, there has been a reduction in the number of beds in institutions such as Quezon Institute, accompanied by the construction of sophisticated medical centers, with fewer beds, such as the Heart Center, Lung Center, Kidney Center and Lungsod ng Kabataan. If the Marcoses had not been deposed, plans would have pushed through for an Eye Center, Brain Center, Trauma Center and International Medical City.

Of greater concern to us are the figures that show a stagnation in the construction of primary level facilities such as rural health units (RHUs) and barangay health stations (BHS). No new RHUs have been constructed since 1980, with 1991 units at that time. There was a rapid increase in BHS construction between 1976 and 1980, followed by a lag in this decade. Today, we have slightly less than 8000 BHS to serve the country's 42,000 barangays. [6]

On a slightly more optimistic note, there are about 14,000 day care centers in the country, under the Ministry of Social Services and Development. This still falls short, however, of the target set by Presidential Decree 1567, issued in 1978, which mandated the establishment of day care centers in every barangay with at least 100 families.

FIGURE 2

HOSPITAL BEDS PER 10,000 POPULATION



All these figures for health facilities are just that: numbers. They indicate availability, but not necessarily their functional status and their accessibility. The number of pay hospital beds, for instance, would exclude a significant percentage of Filipinos from using them. The government Medicare program covers only about 20% of total hospitalization costs, versus 70% when it was first started in 1969. [7]

The rural health units, barangay health stations and day care centers have acquired some notoriety for their lack of equipment and staffers. In a report published in 1983, the Ministry of Social Services noted that about a fifth of its day care centers were inactive, due to the inability of the sponsors to finance the allowances of day care workers. [8]

This takes us to the matter of health workers and professionals. There are still gaps in our data but it is estimated that about half of the total number of Filipino physicians and 65% of the total number of Filipino nurses are presently working abroad. Moreover, those who remain are concentrated mainly in urban areas and are engaged in private practice. The reasons for this massive brain drain will be covered in another paper, but low wages and the lack of opportunities for professional advancement are clearly the main push factors. [9]

In recent years, much publicity has been given to the barangay health workers. The health ministry claimed, at one time, that they had trained some 350,000 health workers, thus bringing primary health care to "99% of the population". Even if we were to accept that figure, with each health worker supposedly serving 20 households, the total coverage would still be only 7 million households or about 70% of the total population. Again, the status of these health workers, and their competence, is still open to question. One regional health director in the Visayas admitted, during the election campaigns, that about a third of the health workers in his area were inactive due to the lack of incentives.

SYNTHESIS

So many more figures could be given for this paper, but by now a clear picture should have been painted for the health situation in the Philippines. At best, we can say that the situation has stagnated. At worst, especially if we consider qualitative aspects that cannot be captured by numbers, the situation has deteriorated by a great degree. Remember that the available figures are mostly updated only to 1983, right before the economic crisis began. It has been extremely difficult to obtain more recent figures and we hope that the new government will take efforts to reveal a more accurate picture to guide those working in health programs.

For instance, a National Nutrition Surveillance System survey conducted in 1984, with a sampling comparable to that of the Food and Nutrition Research Institute (FNRI), showed a rise in the number of under-nourished pre-schoolers, compared with FNRI's figures for 1978 and 1981. In the final analysis, the suppression of data has not even served the purposes of sanitizing the past regime. With or without the nutrition data, the pictures of Joel Abong and the starving children of Negros will continue to haunt us for the years to come, symbols of a government that had neglected its mandate to serve.

III. AN ANALYSIS

It is easy to blame all of our problems on the Marcos dictatorship. To a large extent, certainly, that dictatorship will be remembered for its profligate plundering and pillaging. But we need to situate our analysis in a broader perspective, taking into consideration the many social and historical forces that were, and are present, to understand how health relates to structures.

CULTURAL FACTORS

Our culture, which includes values, attitudes and practices, has been the subject of renewed interest with the recent political events, as social scientists review their perceptions of so-called Filipino values such as *ningas-cogon, hiya* and the like.

In the same vein, we in the health sector need to reexamine the cultural factors that affect our health beliefs and practices. Too often, traditional beliefs and practices, particularly those in rural areas, are named as the primary obstacles to better health. To some extent, it is true that we still have many superstitious and so-called unscientific health practices. But to be fair, we need to recognize that such practices exist among all classes, and include "modern" superstitions.

If our tribal Filipinos continue to have their incantations and rituals for healing, let us not forget the affluent few who flock to psychic surgeons and rejuvenation farms.

If our rural communities continue to insist on using seven leaves of seven medicinal plants for a decoction, let us not forget our dependence on the many irrational and useless drugs on the market.

The fact is that the mass media, and even the educational system, have propagated these unscientific practices. Little has been done to provide useful health education. The expensive AKO campaign (how many remember that?) was an example of so-called health education. In contrast, we are deluged with advertisements promoting tobacco and alcohol. Even more insidious are the "medical advice" columns and articles about "new medical discoveries" that have been paid for by drug companies. Why is it that the most important, yet simple, life-saving technologies such as oral rehydration solutions, get buried under "home and entertainment" while Kargasok tea and key cell therapy get front page coverage?

Let us not forget, too, the direct role the State had in promoting pseudo-scientific movements, many with outrageous claims for better health, such as the Maharishi Unified Field or, in rural areas, the fanatical cults such as the Tadtad, the Corazon Sagrada, and the Rock Christ.

Other cultural fallacies could be cited such as Imelda Marcos' "edifice complex", where emphasis is given on highly visible but often useless projects. Or the fixation on "beautification and cleanliness" projects, presumably to create a germ-free environment for her husband, with his numerous allergies, to live in.

The recent exposés reveal the conjugal dictatorship's love for the true, the good and the beautiful, preferably, of course, imported. And while we deplore all that, we are also victims of a colonial mentality which has made us neglect our own resources that could contribute to a more effective health care system. This colonial mentality has been complicated by medical elitism, the professionals' disdain for the lay person, the unwillingness to make lay people take on more responsibilities for their own health and instead keeping them in a passive and literally patient role.

POLITICAL FACTORS

The physician-patient relationship in our country, with its strong elitist undertones, is of course only a reflection of the political patronage relationships. The health care system, under the Marcos dictatorship, was transformed into a political tool that occasionally dispensed a few transient benefits in an attempt to buy political loyalty. Who can forget those cough and cold remedies with the label MARCOS (Medical Assistance to Rural Communities and Other Sectors), distributed during IMELDAs (Integrated Medical Expeditions to Less Developed Areas)?

Amid all that was the rampant graft and corruption, the tip of which is only now beginning to emerge. An example is the recent discovery that a third of the health ministry's 1986 allocation for drugs had been spent in January alone, during the election campaign . . . a hefty ₱100 million. On a smaller scale was the ₱455,000 spent by the health ministry for chaleko (vests) emblazoned with Marcos campaign slogans.

All of that is still small time compared with the expenditures for Imelda Marcos' various medical centers, all of which were placed under her jurisdiction as Minister of Human Settlements. A probe will probably yield more information, but even the 1984 Commission on Audit report

on these centers already revealed anomalies, which no one dared to investigate. For all the centers, the auditors could only render "a qualified opinion as to the fairness of presentation" of each center's financial statements because of various anomalies [9]:

On the Lung Center: "land, building and equipment donated by the Philippine Charity Sweepstakes Office (PCSO) amounting to ₱380 million have not been taken up in the books of accounts of the Agency. . ."

On the Lungsod ng Kabataan: "the equipment account was not verified due to the failure of management to submit the physical inventory on equipment."

On the Heart Center: "the failure of management to reconcile the physical inventory report on supplies and materials, and property and equipment with the accounting records; and because property and equipment amounting to ₱300.7 million remained unrecorded in the Center's books of accounts."

A "qualified" opinion was also rendered on the National Kidney Foundation Center "due to unsatisfactory result on the confirmation of accounts receivable and the non-reconciliation of the physical inventory of fixed assets with the accounting records." Note, too, that in February 1985, MP Cuenco of Cebu called for an investigation of the use of some ₱350 million of funds from the Philippine Amusement and Games Board (PAGCOR) for the construction of the 50-bed Kidney Foundation Center. [10]

No agency, it seems, was spared from plunder. The Commission on Audit actually rendered "an adverse opinion" on the accounts of the Philippine Charity Sweepstakes Office (PCSO) for various reasons involving more than ₱100 million of funds. The PCSO was created to raise and provide funds mainly for health programs, medical assistance and services. Apparently, it has remained more faithful to its two other mandated objectives: "to engage in health and welfare-related investments, programs, projects and activities which may be profit-oriented" and "to undertake any other activity that will enhance its funds generation operations and funds management capabilities."

When we speak of political factors that affected the health care system under Marcos, we also need to refer to the lack of "political will" to implement programs that would improve the health of Filipinos. There were a few presidential decrees that were ostensibly passed for this purpose. There is, for instance, a presidential decree mandating

immunizations of all children. Reference was made earlier to the "Barangay Day Care Center" decree. Even primary health care was launched with a presidential decree.

All these, however, were also part of political gimmickry. More substantial legislative measures to protect consumers, to assure occupational safety, to regulate the marketing of drugs and infant formula – these were neglected, passed on to a rubber-stamp Batasang Pambansa for endless debates. Few people are aware that one of the last bills passed by the old Congress before it was closed down by martial law was one that required the printing of warnings about the hazards of smoking on all tobacco products, cigarettes. That was in 1972. Thirteen years later, similar bills were still being proposed at the Batasang Pambansa.

In contrast, presidential decrees and laws have been passed to institutionalize political repression. Presidential Decree 169, requiring hospital administrators and physicians to report all gunshot wound cases to the local Philippine Constabulary (PC), was obviously a counter-insurgency ploy. That presidential decree has blocked many professionals from giving their services. But even without PD169, the assassination of Bobby de la Paz in 1982, and the arrests and harassment of health professionals working in rural areas, have discouraged people from serving in these depressed areas.

Militarization itself has caused health problems. Besides the deaths directly caused by "acts of war" (registering increases as reported in the *Philippine Health Statistics* during the 1970s), military operations have dislocated people from their livelihoods, and have forced entire villages to live in congested camps, easy prey for disease and malnutrition.

The matter of political will brings us to the national budgets, the passage of which was generally railroaded through the Batasang Pambansa. The Marcos era saw a steady decline in the share of the national budget for education, health and other social services, in favor of the military and debt service.

ECONOMIC ASPECTS

Debt service has, in fact, driven us literally to the death bed. We generally recognize the relationship between poverty and ill health, but may leave such issues as foreign debts to the economic and financial experts. But the macro-economic structures were and are important factors associated with health.

Our huge foreign debt has placed the country under greater control by foreign interests. Directly affecting us in health is the heavy control of multinational drug companies and medical equipment suppliers. As the peso value dropped, imports became more expensive, setting a chain reaction in the health care system from the hospitals to consumers.

Taxes have further increased the prices of essential commodities and many of these new taxes were imposed to generate income for the government for debt service. Loans, including several sizeable ones to the health ministry, did not develop the country for much of the money was misused, diverted toward unproductive projects, or salted away abroad.

All this while our people slaved away with wages that were deliberately kept low, providing a cheap labor force in an attempt to attract foreign investors. This policy actually contributed to a stagnation of the health sector. The needs are there, but the paying public, the market so to speak, has remained small or may even have contracted.

Businesses have preferred to cater to the small but wealthy elite. Drug companies opted to keep their profits high by maintaining drug prices at a level that only the high-income groups could shoulder. The domestic market has therefore been quite small and has, in fact, been used as an excuse by the pharmaceutical industry to maintain local operations at the level of packaging, rather than actual manufacturing.

What are the dimensions of this poverty, this lack of purchasing power in a society where, unfortunately, health become a commodity. Last year, in Las Piñas, we interviewed a woman from an urban poor community whose child had died from diarrhea. The mother had brought the child to a hospital. At the admitting section, they asked her to pay for an admission card, which she could not afford. They were asking for ₱2.50. She only had ₱1, enough for her to bring home her child. By the time she had borrowed enough money to return to a physician, the child's condition had deteriorated.

Our country is rich in natural resources, but the distribution of these resources has been so skewed. In terms of income, the top 1% of the population controls nearly 12% of the total "pie", while the poorest 20% must content themselves with 3%. Official figures on income distribution have been unavailable since 1975, but economists have made independent studies, the results of which suggest a widening gap between the rich and the poor during the last decade. [10] Given this situation, it is not surprising that there has been a corresponding deterioration in the health situation of low-income families, who form the majority of the population.

CONCLUSION

The new government has inherited a ravaged economy and political structures with nearly zero credibility. The crisis remains with us.

There will be no easy solutions and in fact, some of the problems may continue to grow. Health economists suggest, for instance, that the full impact of an economic recession on health and nutrition may be delayed by two or three years.

Our agenda for a restructuring of the health care system must focus on a number of urgent issues such as graft and corruption; incompetent and oppressive political appointees in health institutions; the low wages of health professionals and workers; the decline in the quality of medical and nursing education; the serious deterioration of health care facilities, particularly at the primary level; the continuing stranglehold of multinational drug companies and medical suppliers.

There will be both short and long-term strategies to tackle these issues. The point is that whether we speak of short or long-term solutions, we have to start somewhere. The health ministry's housecleaning is a positive step, but there will be more work ahead, beyond reorganizing or rationalizing the bureaucracy.

To use medical terms, both preventive and curative measures have to be initiated. Old wounds will heal, but we need to take steps to insure the viability of continuing change. Organized, inter-sectoral efforts are vital, to protect the rights that have been restored, even as we work for the other rights still unattained. Surveying the havoc and the damage wreaked by the Marcos regime, we must never again allow another dictatorship.

Open Forum

At the open forum that ensued, the participants emboldened by the "liberal atmosphere" took turns to share their views and present sectoral problems.

Dr. Metodio Palaypay, vice president of the Philippine Chamber of Health decried the inadequacy of health education in the country, notably in dealing with environmental and sanitation problems.

He said that though there are 1,700 sanitary inspectors nationwide, nothing much can be expected from them, because they are ill-trained

and because most of them are "ex-cops, ex-musicians or ex-bodyguards of mayors."

He urged the review of the health care system and warned that the country is becoming "too much beholden to the WHO (World Health Organization) consultants" who are using the Philippines as a "guinea pig."

Dr. Florence Tadiar, director of the UP Institute of Public Health Hospital Administration Program said that health professionals also deserved to be blamed for the deterioration of the health situation. She called for changes in attitudes and values, urging her colleagues to be "more responsible" in handling medical reports and statistics.

Edna Suanes, chief nurse of the Ospital ng Maynila urged the labor ministry to act on the nurses' applications to some 3,000 nurses' posts needed by the Saudi Arabian government. However, she added that local nursing posts should be filled up first before nurses are allowed to leave for abroad.

Nursing representatives also took occasion to discuss a new health ministry directive that was causing a lot of sleepness nights among the country's chief nurses.

Last March 17, the health ministry issued order no. 15 which called for the resignations of all government health officials from the rank of deputy health ministers down to division chiefs.

Anesia Dionisio, president of the Association of Nursing Service Administrators of the Philippines (ANSAP) said that the ministry's order is "threatening the security (of tenure) of chief nurses" and warned that the public may have to bear the brunt of poor nursing services if the trained nurses are forced to vacate their hard-earned posts.

Other nursing representatives also deplored the quality of graduates that the country's 118 nursing schools turn out.

"It requires a lot of white hair to accept the new products," said Sr. Marie Cabagon of Medical Center Manila.

The chief nurse of the Philippine General Hospital Perfecta Nicolas said that there are graduates who do not know the difference between a cleansing bath and tepid sponge bath or the difference between an IV (intravenous) set and a blood transfusion set.

Tadiar said that most nurses refuse to serve in rural areas and even sophisticated medical centers have lost its attractions to nursing graduates who go abroad after stints in these specialty centers (e.g. the Heart Center).

Most of the participants lauded the task force's efforts in initiating public discussions on health, emphasizing that much remains to be done especially in areas of research.

The first lecture and forum got off an auspicious start with the health professionals and workers acknowledging that now is the best time to clean up their ranks and to work toward a more responsive and people-oriented health care system.

FOOTNOTES

1. The figures given here, and in the appendix, are computed from statistics released by the Health Intelligence Service, *Philippine Health Statistics* (Manila: Ministry of Health) for the years 1966 to 1983.

2. Ministry of Health (Planning Division), *National Health Survey 1981* (Manila: Ministry of Health).

3 As of 1983, communicable diseases accounted for 34% of total deaths, according to the Health Intelligence Service.

4. M.L. Tan, "Mending Broken Hearts", *Health Alert*, February 15, 1986, pp. 2-8.

5. National Institute for Tuberculosis (NIT), *Current Epidemiological Status of Tuberculosis and Problems Encountered in its Control*, n.p., n.d. (Mimeographed report, based on studies conducted in 1981.

6. Figures released by the Bureau of Medical Services, Ministry of Health.

7. *Business Day*, March 28, 1985 and April 11, 1985.

8. *A Decade of Accomplishments* (Manila: Ministry of Social Services and Development, 1983).

9. *1984 Annual Financial Report*, Volume II (Government-owned and Controlled Corporations), Statement No. 54 on Educational, Cultural, Scientific and Civic Organizations. (Commission on Audit).

10. *Business Day*, February 28, 1985 and March 21, 1985.

11. *Bulletin Today*, July 7, 1985.

CHAPTER 2

Issues and Concerns of Health Workers on their Quality of Work Life — Implications for Social Policy

Minda Luz M. Quesada

INTRODUCTION

This paper is an attempt to focus on the perennial issues and concerns affecting the quality of work life of health workers in both government and private health care institutions and organizations. It aims to generate interest, discussion and action among concerned individuals and policy/decision makers.

Modern management has given increasing attention to the quality of work life of individuals in organizations – how it affects the productivity of work organizations, how it affects the psychological well-being of workers, and how it can be changed and improved for the benefit of both.

The areas of concern and activity encompassed by the phrase *quality of work life* are broad and diverse, and many of the terms used to describe these areas imply different things to different people. To some, according to J. Lloyd Suttle [1] of Yale University, it refers to industrial democracy, increased worker participation in corporate decision-making, or a culmination of the goals of the human relations movement of two decades ago. To others, especially those in management, the term suggests any of a variety of efforts to increase productivity through improvements in the human, rather than the capital or technological

inputs of production. Union and worker representatives on the other hand, view the quality of work-life as leading to a more equitable sharing of the income and the resources of the work organization and to more humane and healthier working conditions.

Richard Walton (1974) [2] proposed a comprehensive definition of quality of work life presenting eight major conceptual categories as a framework for analyzing and assessing the phenomenon:

1. Adequate and fair compensation – Does pay received meet socially determined standards of sufficiency or the recipient's subjective standard? Does pay received for certain work bear an appropriate relationship to pay received for other work?

2. Safe and healthy environment – That employees should not be exposed to physical conditions or work arrangement that are unduly hazardous or unhealthy is widely accepted.

3. Development of human capacities – To varying degrees, work has become fractionated, deskilled, and tightly controlled; planning the work is often separated from implementing it. So jobs differ in how much they enable the worker to use and develop his skills and knowledge, which affects his involvement, self-esteem and the challenge obtained from the work itself.

4. Growth and security – Attention needs to be given to a) the extent to which the worker's assignments contribute to maintaining and expanding his capabilities, rather than leading to his obsolescence; b) the degree to which expanded or newly acquired knowledge and skills can be utilized in future work assignments, and c) the availability of opportunities to advance in organizational or career terms which peers, family members or associates recognize.

5. Social integration – Whether the employee achieves personal identity and self-esteem is influenced by such attributes in the climate of his work-place as freedom from prejudice, a sense of community, interpersonal openness, the absence of stratification in the organization and the existence of upward mobility.

6. Constitutionalism – What rights does the worker have and how can he (or she) protect these rights? Wide variations exist in the extent to which the organizational culture respects personal privacy, tolerates dissent, adheres to high standards of equity in distributing rewards, and provides for due process in all work-related matters.

7. The total life space – A person's work should have a balanced role in his life. This role encompasses schedules, career demands, and travel requirements that take a limited portion of the person's leisure and family time, as well as advancement and promotion that do not require repeated geographical moves.

8. Social relevance – Organizations acting in a socially irresponsible manner cause increasing numbers of their employees to depreciate the value of their work and career. For example, does the worker perceive the organization to be socially responsible in its products, waste disposal, employment practices and participation in political campaigns?

What might be gained from improved quality of work life?

Studies here and abroad have shown that improvements in the quality of work life have resulted in higher job satisfaction, increased individual productivity, a stronger commitment to the organization's goals, greater self-esteem among workers, improved physical and psychological health, greater growth and development of the individual as a person and as a productive member of the organization, decreased absenteeism, turnover, defiance of rules and authority, grievances, sabotage, theft, and strikes.

The conditions contained in the preceding conceptual framework has been the focus of concern by health workers for many years. These has also been the subject of ILO Convention 149 and Nursing Recommendation 157 in relation to employment and conditions of life and work of nursing personnel.

In an effort to translate the Government's commitment to ILO Convention 149 ratified by the President then, Ferdinand E. Marcos on 1 May 1979, [3] the Ministry of Labor and Employment convened the 1st national tripartite conference on September of that year. It included other health workers employed in the health care industry in the deliberation of issues and proposals concerning labor standards, labor relations and industrial growth and viability. The product of this exercise in tripartism was a Joint Communique [4] signed by labor (represented by the Philippine Nurses Association and the Trade Union Congress of the Philippines), management (represented by the Philippine Hospital Association) and government (represented by the Ministry of Labor and Employment).

Follow-up actions were made by the Philippine Nurses Association and the National Hospital Employees Association to the Office of the President and the Batasang Pambansa. When all these failed, health

workers resorted to different forms of assertive actions like pickets, mass delegations, ribbon-wearing, rallies, march-demonstration. All these were aimed to press for governmental action on improving their work life conditions. Nothing significant was achieved.

The legal bases for health workers' struggle for economic and democratic benefits are to be found in the 1973 Constitution of the Philippines, [5] the New Labor Code and ILO Convention 87, [6] to wit:

Art. 2, Sec. 9 of the 1973 Constitution: "The State shall afford protection to labor, promote full employment, ensure equal work opportunity regardless of sex, race, or creed and regulate the relations between workers and employers. The State shall assure the rights of workers to self-organization, collective bargaining, security of tenure, and just and humane conditions of work. The State may provide for compulsory arbitration."

Convention No. 87 Article 2, "Workers and employers, without distinction whatsoever, shall have the right to establish and, subject only to the rules of the organization concerned, to join organization of their own choosing without previous authorization."

But even more fundamental than these laws are their rights enshrined in the Universal Declaration of Human Rights [7] which states:

Article 23, Sec. 1: "Everyone has the right to work, to free choice of employment, to just and favorable conditions of work and to protection against unemployment . . . Section 3: "Everyone who works has the right to just and favorable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection."

Health workers constitute the labor force of the country which provide a basic social service to its citizenry so that the latter could contribute productively to national growth and social development. This role becomes even more pronounced under the new government of President Corazon C. Aquino who has spelled out a social policy that would put a stress on the provision of adequate social services like health and education to majority of our people.

Health workers' participation in national reconstruction efforts, however, will require that their own very basic human needs of food, clothing, shelter, be addressed to. It would be difficult to rely solely on exhortations for them to sacrifice some more and show more devotion to their work when they who provide care are not cared for. It is unkind

and unfair of anyone to demand from the overworked and underpaid health workers selflessness in the midst of their own deprivations and suffering.

What then are these pressing work life issues and concerns which have continually plagued health workers in various health care settings (hospitals, factories, schools, communities and clinics)?

Would the new government of President Aquino be more responsive to their demands which the past regime only gave token attention to?

HEALTH WORKERS QUALITY OF WORK LIFE ISSUES AND CONCERNS

1. Shamefully low, unjust, inhuman wages and salaries.

As health care providers, health workers are expected to be good role models of health. They need to be healthy in order to be able to have the energy, strength and resistance to carry on long hours of work and not to get sick themselves especially after being exposed to communicable diseases and other hazardous/deleterious conditions. But with starvation wages, how can an ordinary health worker attain a minimum level of health and well-being? Consider the following:

* A staff nurse in a government health institution receives a basic salary of ₱1,068.75 (after the 25% salary hike implementation), COLA of ₱350 per month and a subsistence pay of ₱180 or a gross monthly income of ₱1,598.75. With a total deduction of about ₱400 (GSIS, Medicare, Pag-ibig, Withholding Tax), her take-home pay will only be about ₱1,120. The nurse counterpart working in the private sector receives just about the same amount based on the daily wage (effective minimum wage) of ₱57.08 which computed for 22 days will amount to ₱1,254.

* Other categories of health workers definitely receive much less. A government hospital attendant only receives a measly ₱835 a month gross income. It is not surprising that they are forced to seek extra jobs to the detriment of their efficiency and effectiveness in delivering health care.

* Or an institutional worker with a monthly salary of ₱666 who has to support a family of six, pay for their education, spend for transportation and food while on duty, and obtain most essential

goods for their sustenance. Even with a COLA of ₱350 a month and subsistence pay of ₱180, how far can this total income go?

*In mid-1984, the poverty line was already estimated at ₱2,502.98 a month and the estimated daily cost of living for a family of 6 in Metro Manila was ₱105.38.

(See Appendix for a comparative listing of salary scales and benefits of other paramedical workers in the Ministry of Health.)

2. Understaffing/overloading of health staff.

These affect the quality of health care because the standards of health care cannot be effectively implemented. For example, in some big government hospitals, the ratio of nurse to patient load is as high as 1:120. This problem is ironic when there is a big supply of nurses produced each year by the 142 colleges of nursing, averaging from 10-11,000.

In the study of Agagan in 1980, she computed the minimum demand for staff nurses in Metro Manila government and private hospitals is about 30,215 but only 11,238 are actually employed. Some hospitals have actually resorted to the use of "volunteer nurses" who serve as a source of cheap nursing manpower. At the same time these newly graduated nurses are able to acquire a certification of the hospital clinical nursing experience required for overseas employment.

The problem of understaffing is compensated by some hospitals through the use of health students in providing needed health care. This practice, however, is an exploitative practice resorted to as a means of cutting down on health manpower costs, but which should be discouraged since this affects the quality of the education and training of the health students.

One consequence of understaffing is the practice of making health workers to go on overtime work without pay. In some instances, health workers like nurses and nursing attendants are obligated to go on extended duty, as long as sixteen duty hours.

3. Inadequate fringe benefits to compensate for low wages/salaries.

This refer to the ₱350 monthly cost-of-living allowance (COLA), ₱6/day, hospitalization benefits, hazard pay, night shift differentials, and clothing allowance.

While there are existing directives to provide some of these benefits, their implementation is always subject to availability of funds. For example, majority of the hospital workers of communicable disease hospital who are entitled to hazard pay (being constantly exposed to infectious agents of disease) have not enjoyed this benefit. What is even more demoralizing is the fact that when they get sick of communicable disease they are confined in the charity wards instead of the infirmary for employees and that they have to pay for all medicines.

4. Lack of security of tenure.

Many workers such as institutional workers whose services are essential to the delivery of health care are still employed as casuals even after satisfactory services of more than 5 years.

In private institutions, health workers feel the threat of losing their jobs even for the flimsiest of reasons, but most often when the workers are becoming assertive and actually start organizing efforts in their institutions.

The current source of insecurity among government workers is the directive for all health officials down to the division chief levels to tender their courtesy resignation. While these do not apply to the rank-and-file, somehow this governmental action has put a cloud on whether career or civil service rules will be observed in the process of effecting organizational changes.

5. Lack of enjoyment of genuine democratic rights of health workers.

This would refer to health workers right to organize or to join associations of their own choice, freedom of peaceful assembly within the premises of the hospital or agency, the right to collective negotiations concerning their work life conditions and the right to speedy and due process of resolving legitimate grievances.

The 20 years of the Marcos dictatorship has repressed these fundamental rights of 'free' workers. Even until now, there are vestiges of the 'dictatorial' attitudes and behavior of management in both government and private institutions. It is not uncommon to observe the repressed behavior and attitude of rank-and-file workers even after the February people power revolution which should have set them free.

Through the Martial Law years, graft and corruption has been perpetuated, even legitimized, because of the absence of effective fiscalization and social controls which health workers' organizations could provide if only they were free to assert such controls.

6. Fast turn-over of health manpower.

Health facilities (hospitals, rural health units and medical centers) are constantly plagued with the problem of resignations of highly trained and skilled health manpower. This has affected the quality of health services and burdened with the high cost of a staff training and development.

The health sector is known to be a contributor to the phenomenon of brain-drain or reverse transfer of technology. This may be explained by the following factors:

1. Poor working conditions and the desire of health professionals to seek greener pastures.

2. Unemployment or the lack of appropriate job opportunities in the country.

3. The desire of health professionals to upgrade their technical skills or to apply their western oriented know-how.

4. The encouragement of government policy-makers to health professionals to seek overseas employment as this would bring in much-needed foreign exchange earnings to pay foreign debts.

Overseas employment however, has created other social problems which counterbalances its desired benefits, namely, that it: a) deprives the country of much-needed trained health manpower, b) wastes the social investments in these important human capital, c) deprives the country of potential tax returns, d) creates social problems among families, e.g. broken families, mental health disorders, etc., e) reflects government's inability to transform human resources into productive forces for national development and f) satisfies needs of developed countries to have cheap labor in their own health care system and health/industrial establishments.

8. Inadequate facilities and supplies to render quality patient/health care to patients and other client populations.

These conditions so prevalent in government health institutions compound the rest of these work life conditions since these frustrate, impede the help-giving and caring ideals among our health workers when they are powerless or helpless to prolong life, heal the curable or prevent unnecessary deaths and disease.

For example, health workers complain of their frustration when they have to tell patients or their families to buy much-needed medicines or supplies before any emergency intervention could be made. As a result of implementing this hospital policy in governmental hospitals health workers have to bear the brunt of the public's anger for their seeming indifference or callousness. This perennial situation has unconsciously transformed the once-caring health workers to alienated beings as a defense mechanism to their suffering brought about by their powerlessness to remedy the situation.

9. Lack of opportunities for health workers to grow and develop in their potentials and experience a sense of worth and dignity in their work.

Many health workers complain that there are not enough programs within their institutions that would encourage their development as individuals with potentials. Also, they often experience dehumanizing treatment from superiors when for instance they are scolded in front of patients, their families or co-workers, berated like they were small children, and subjected to other abusive acts as if they had no feelings.

They also deplore the fact that management and supervisors seldom give praise for good things done but are quick to notice inadequacies or misdemeanors.

There may be many more of these issues and concerns but these situations are the most frequently cited ones, either individually or collectively in small and big group forums/dialogues and discussions.

RECOMMENDATIONS FOR SOCIAL POLICY

1. Conduct a serious health manpower production/management study to have a comprehensive situationer of the status of health manpower in the country.

Government bodies like the Ministry of Health, Ministry of Education, Culture and Sports, and the Ministry of Labor and Employment do not have any comprehensive data on the status of health manpower development in our country today. This information is needed if the new government wants to develop a rational health manpower plan.

2. Review and rethink national policy concerning the exportation of skilled health manpower and to focus on how these resources could instead be utilized productively for our country's needs.

The unwritten policy of the past regime which encouraged the exportation of human resources should be changed so that our health manpower resources, vital to our efforts at social development could be fully harnessed to serve our country's needs and interests.

3. Increase the health budget to ensure that the majority poor and disadvantaged would have access to health care.

Provisions should be made that the budget allocated for health is equitably distributed according to the needs of population, i.e. rural vs. urban areas, preventive vs. curative services, essential drugs and supplies vs. infrastructures, etc.

4. Upgrade or give just, humane salary/wages to health workers.

The national budget for Personnel Services or Salary Adjustment Funds should appropriate for a yearly upgrading of health workers (which should include paramedical and non-medical or administrative support staff) salary. The increment should be based among other considerations, on the Consumer Price Index (CPI) to ensure that health workers' basic needs can be met.

5. Institutionalize mechanisms for democratic consultations in health care institutions in both government and private hospitals.

Recognize the right of health workers in government hospitals to organize associations or unions for collective negotiations for the improvement of their work life conditions.

In order to ensure that health workers enjoy their right to self-organization and peaceful assembly the government should adopt sanctions for those who prevent the exercise of these rights.

6. Implement recommended staffing patterns and standards of health care to ensure that our people receive quality care.

There are existing recommendations on staffing and standards of health care which need to be strictly enforced by the regulatory bodies of the government.

7. Enforce legislations which should protect and compensate health workers from occupational hazards and illness/accidents acquired in the line of duty.

Information should be widely disseminated on these legislations, e.g. hazard pay, Employees Compensation Commission (ECC) which provide for illness/accidents required in the line of duty.

There should be sanctions made on authorities who prevent health workers from enjoying these benefits.

8. Institutionalize continuing health manpower training and development to enable rank-and-file workers to avail of educational opportunities for personal growth and development.

Training programs in health institutions should not only educate or train health workers on the technical aspects of their job but should include dimensions such as interpersonal relations, assertiveness, organizing and managing groups or associations, social values and leadership.

9. Convene a national tripartite conference to discuss the current employment and work life conditions of health workers in private and government institutions.

Initial talks have already been made among the three sectors – labor, hospital management and government, under the initiative of the Employees Compensation Commission (ECC) during the Marcos regime. This was triggered by the applications of some hospitals for loans from the ECC. The labor representative in the ECC thought that granting government assistance to private hospital owners would be one-sided if there are no corresponding benefits for hospital workers.

The 1979 Joint Communique could be used as term of reference should a second tripartite conference be called. (see Appendix B).

Before convening such a conference, the parties to represent the labor and management panels should be duly authorised by the sectors they represent and should be authorized to commit their membership to the conditions agreed upon during the conference.

Open Forum

According to former Philippine Medical Association (PMA) President Jose Pujalte, medical graduates face a dearth of job opportuni-

ties. Government and private hospitals are unable to offer slots for residency training, he said.

In the National Orthopedic Hospital which he heads, Pujalte said that half of 37 young doctors vying for a slot "have been waiting for the last three years for somebody to collapse."

Conversely, he said that few doctors are willing to be lured into rural practice owing to the dismal peace and order situation in many provinces.

Philippine Pharmaceutical Association representative Erlinda Santos bewailed the image of pharmacists as little more than "glamorized sales girls." She stressed the importance of pharmacists in the health delivery system adding that a new group of health workers called pharmacy technicians/aids is being readied to make health services accessible to all. She appealed to the audience to help refurbish the pharmacists' public image.

Three labor ministry (MOLE) officials led by Bureau of Working Conditions Director Augusto Sanchez, who attended in lieu of Labor Minister Augusto Sanchez (no relation) pledged the willingness of MOLE to listen to plaints of health workers. Sanchez' reiteration of the new labor minister's policy that "those who have less in life will have more in law" was warmly received by the audience.

Reacting to a query that the MOLE is "ganadong-ganado" (overenthusiastic) in exporting skilled health manpower, Sanchez said that the labor ministry was merely responding to health workers' clamor for jobs abroad and that under the new set-up, the export of manpower will only be temporary.

Dr. Wilson Estrada, labor standards research division chief, said that the MOLE could hardly be faulted if the trained health manpower prefer to go abroad since the MOLE's functions are to facilitate overseas job placements and ensure that workers are not exploited. Instead, he said that the educational system that produces health professionals who opt for foreign service should be reexamined.

Dr. Carol Araullo, Task Force member, urged the MOLE to approve the export of skilled manpower only as a "stopgap" measure since "we are only impoverishing ourselves" with the unabated exodus of health professionals.

During the open forum, it was decided that an appeal should be made to the National Economic Development Authority (NEDA) to conduct a health manpower production/management study to ensure that the country is producing the right amount of health manpower for its own needs.

Dr. Ed Clemente of the Capitol Medical Center said that just as it is important to increase the health budget, the people in the health sector should also closely monitor how and where the budget is being spent. He suggested that pharmacists can readily enhance their poor image if they serve as public watchdogs in determining the efficacy and safety of drugs that are manufactured.

He also urged health professionals to take advantage of a liberated Philippine press by exposing health concerns and issues that have remained closeted during the Marcos regime.

A number of health professionals said that health expenditures should be channeled primarily toward preventive health measures benefiting the poor majority. Another volunteered that the health ministry should not overlook the 350,000 barangay health workers in terms of budgetary allocations since they play crucial roles in the rural health care system.

Clearly, the more popular recommendations among the health workers and professionals were those calling for higher pay, better working conditions, a stop to exploitative practices in hospitals that prey on health deliverers and would-be health providers, enforcement of laws that would protect health workers from occupational hazards and the right to organize.

The forum also featured some "scoops" of its own. For instance, Dr. Jose Pujalte revealed that in his capacity as hospital chief, he was asked by the former health ministry under Dr. Jesus Azurin to restrain his hospital employees from participating in health workers' activities notably those organized by the militant Alliance of Health Workers. He had to follow the order even though "my heart bleeds," said Pujalte.

A San Lazaro Hospital nurse disclosed that the hospital used to pad its admission lists with "ghost patients" just to wrangle a bigger slice of the government budgetary pie.

SALARY AND ALLOWANCES OF ALLIED MEDICAL POSITIONS IN THE MINISTRY OF HEALTH, PHILIPPINES							
	NO. OF POSITIONS	MONTHLY			TOTAL	TOTAL MONTHLY	TOTAL ANNUAL
		SALARY	COLA	OTHERS			
MED. POSITIONS PHYSICIANS	8,970	2,553	300	235	3,088	27,699,360	332,392,320
ALLIED MEDICAL POSITIONS							
NURSE	13,655	774	350	235	1,359	18,557,145	222,685,740
DENTIST	1,915	1,043	350	231	1,624	3,109,960	37,319,520
PHARMACIST	616	855	350	235	1,440	887,040	10,644,480
MED.TECH.	832	855	350	235	1,440	1,198,080	14,376,960
CHEMIST	235	855	350	235	1,440	338,400	4,060,800
HEALTH EDUCATOR	133	855	350	25	1,230	163,590	1,963,080
NUTRITIONIST	300	898	350	25	1,273	381,900	4,582,800
DIETITIAN	520	774	350	235	1,359	706,680	8,480,160
OCCUPATION							

THERAPIST	53	774	350	235	1,359	72,027	864,324
PHYSICAL THERAPIST	30	774	350	235	1,359	14,770	489,240
HOSP. LICENSING OFFICER	12	1,894	300	25	2,219	26,628	319,536
HEALTH PHYSICIST	11	1,894	300	25	2,219	24,409	292,908
CLINICAL PSYCHO.	8	1,272	350	235	1,857	14,856	178,272
ZOOLOGIST	6	1,211	350	25	1,586	9,516	114,192
ENTOMOLOGIST	22	1,096	350	25	1,471	32,362	388,344
BACTERIOLOGIST	69	898	350	235	1,483	102,327	1,227,924
MALARIOLOGIST	53	813	350	25	1,188	62,964	755,568
MEDICAL RADIATION TECHNOLOGIST	12	774	350	235	1,359	16,308	195,696
MIDWIVES	8,694	603	350	25	978	8,502,732	102,032,784
SANITARY INSPECTOR	2,260	546	350	25	921	2,081,460	24,977,520
SUB-TOTAL	29,436					36,329,154	435,949,848
GRAND TOTAL	38,406					64,028,514	768,342,168

NOTE: TOTAL AMOUNT BASED ON LOWEST LEVEL OF POSITION CLASS FIGURES AS OF 1985, EXCLUDING THE 25 PERCENT SALARY INCREASE GRANTED THROUGH EXECUTIVE ORDER 1061.

SOURCE: OFFICE OF COMPENSATION AND WAGE CLASSIFICATION, MINISTRY OF BUDGET'

APPENDIX B

NATIONAL TRIPARTITE CONFERENCE ON EMPLOYMENT AND CONDITIONS OF WORK AND LIFE OF NURSING AND OTHER HEALTH PERSONNEL

JOINT COMMUNIQUE

Part I. Magna Carta for Nursing and Other Health Personnel

The government is strongly urged to enact immediately a Magna Carta of Rights and Obligations for Nursing and Other Health Personnel in line with the treaty obligations of the Philippines under ILO Convention 149 and the principles adopted in this Conference.

Part II. Labor Standards

The parties shall submit for the consideration of the President their respective positions on wages and other conditions of employment as follows:

A. Workers' Position

1. All workers, whether professional or not, in the health care industry who are now paid on a daily basis shall be convened to monthly-paid employees. The 40-hour workweek shall be applied universally to hospitals, regardless of their location or bed capacity.

2. Professionals in the industry shall be paid a minimum basic salary of P900 a month and all the mandatory allowances decreed by law without exemptions. The mandatory allowances of non-professional workers shall be integrated into their monthly basic salary.

3. Government and private hospitals shall enforce the Nursing Personnel System embodied in ILO Convention 149 and the nursing staffing pattern prescribed by the Bureau of Medical Services of the Ministry of Health.

4. To enable the implementation of the Nursing Personnel System in the country, certify the urgency of the approval of Parliamentary Bill 466, otherwise known as the Philippine Nursing Act of 1979.

B. Employer's Position

1. With respect to wages and all labor standards, status quo.

C. Government's Position

1. All workers, whether professional or not, in the health care industry, who are paid on a daily basis shall be converted to monthly-paid employees, provided that:

(a) those who are now covered by the 40-hour workweek law shall continue to work on a 40-hour workweek basis, while

(b) those who are not covered by the 40-hour workweek law shall continue to work on a 48-hour workweek basis.

2. Professionals in the private sector of the health care industry shall be paid a minimum basic salary and allowances in parity with the minimum basic salary and allowances of professionals in the public sector of said industry, provided that distressed employers may be exempted to the extent and under the procedures prescribed under PD 1634.

3. Upon the full implementation of the principles set forth under Part IV on Industrial Viability and Growth, the parties shall convene anew in a conference for the purpose of improving further the conditions of work and life for nursing and other health personnel.

It shall be understood that the respective positions herein stated shall be construed as indivisible, package formulae.

The employers agreed in principle to adopt the government positions on the condition that the provision on parity apply according to the following schedule: 100 % for tertiary hospitals, 85 % for secondary hospitals, and 70 % for primary hospitals.

Part III. Labor Relations

* Workers in non-profit institutions shall have the right to self organization and collective negotiations.

* Preventive suspension shall be limited to thirty days.

* Whenever an illegally dismissed employee is reinstated, he shall receive full back wages with legal interest and without deductions whatsoever.

* Two additional members representing labor shall be appointed to the Board of Directors of the Philippine Medical Care Commission. Labor shall also have at least one representative in the Provincial, City, and Municipal Medical Care Councils.

* To develop cooperative understanding between labor and management, the provisions of the Labor Code should be emphasized in the curricula of all secondary schools. The Ministry of Labor, in coordination with the Ministry of Education and Culture, should conduct seminars and symposia for school administrators and faculty members.

Part IV. Industrial Viability and Growth

* A government council on the health care industry shall be created in the Ministry of Health, with representatives from and chosen by each of the sectors concerned to look closely into and monitor the operations of the industry and explore various alternatives to ensure the continued viability and growth of the industry.

* Pay wards in the government hospitals shall be phased out, except in places where there exist no private hospitals, so that the government hospitals can concentrate on purely medicare and health services for indigents.

* Private hospitals with financial loans from government-lending institutions shall be granted a moratorium of seven (7) years in the payment of amortizations during which period only interests will be paid. They shall also be granted a total of 25 years from date hereof of within which to liquidate the entire loan.

* All electric power companies, including NEA-supported operators shall be required to give private hospitals duly registered with the Bureau of Medical and Health Services of the the Ministry of Health the same electric rates as government hospitals.

* Private hospitals, being essentially public service institutions, should be granted concessions on utilities such as telephones, sewerage, and other similar facilities.

* Private hospitals not used for residential purposes should be considered as public buildings, and be given all the privileges under P.D. 1096.

* The 10 % tax on hospital revenue should be levied on net, instead of gross, income (similar to that granted to private schools).

* The increase on capital gains and/or accrued or unearned increments of hospitals should be tax-exempt in order to encourage investments in hospitals.

* The tax privileges granted on imported hospitals equipment under P.D. 1258 should be implemented and should include medicines and hospital supplies.

* The Bureau of Internal Revenue shall fully implement Section 2, R.A. 6615 granting hospitals a P50,000 tax credit from income taxes within a period of five years for attending to indigent patients. The tax credit granted on expenses and losses incurred by private hospitals for services extended to emergency cases shall be implemented.

* The President shall be requested to issue a letter of instructions for strict implementation of existing guidelines regulating collection of professional fees in the health care industry.

* The possibility of having absconding patients being held liable for estafa under Article 315 of the Revised Penal Code shall be studied. Nurses and other health care personnel should not be made liable for bills incurred by absconding patients.

* Fifteen or twenty per cent of the professional fees of physicians and other health professionals shall be creamed off for incorporation into special hospital fund. This fund shall be apportioned to the labor and management sectors: provided that the share of the labor sector shall be distributed equitably among the workers. In this connection, professional fees should be paid through the hospital. The objection of the Philippine Medical Association on this point is however, hereby noted and attached to this communique.

* The 10 per cent withholding tax presently being taken from the professional fees of physicians and other health care professionals by the Bureau of Internal Revenue shall be allocated proportionately: management proposing that the appointment be 60 % for wage adjustment and 40 % for hospital expansion, while the labor sector asking for a 70 % - 30 % ratio.

* Monetary gains from all measures that have been approved should be quantified and be made part of the hospital funds from which increases and adjustments of salaries and wages, as well as improvements of hospital facilities, may come.

* Further deliberations shall be undertaken on the creation of employment opportunities for nurses in the barangay level, inasmuch as funds are available for this purpose.

* Labor reserves the right to withdraw its support for the measures contained in this Part if its position stated in part II hereof receives no concession or acquiscence from the employers.

Part V. Health care Delivery System

Health Maintenance Organizations (HMOs) shall be established to be composed of physicians and para-medical groups that will provide total medical, surgical and hospital care (including prevention, early diagnosis and treatment, acute care and convalescent care) on pre-paid basis through public or government contributions determined by actuarial studies.

PICC, Manila, 29 September 1979.

Original Signed
AMADO G. INCIONG
Chairman

Original Signed
Minda Luz M. Quesada
Vice-Chairman for Labor

Original Signed
Carlos P. Crisostomo
Vice-Chairman for Management

Not authorized to bind the
private individual hospital
members of the Association
plus attached clarifications.

ATTESTED:
Original Signed
BLAS F. OPLE
Minister of Labor

FOOTNOTES

1. Suttle, J. Lloyd and Hackman, J. Richard. *Improving Life at Work: Behavioral Science Approaches to Organizational Change.* Sta. Monica, California, Goodyear Publishing Company, 1977.

2. Walton, R.E. "Improving the Quality of Work Life", *Harvard Business Review,* May-June, 1974.

3. Proclamation No. 1851, signed by President Ferdinand E. Marcos on May 1, 1979, ratifying ILO Convention 149 Concerning Employment and Conditions of Work and Life of Nursing Personnel. A Convention is like a Treaty which if ratified by a Member State of ILO binds the Government to institute social measures to implement the provisions of the Convention. As a result of the Proclamation, the Ministry of Labor convened the 1st national tripartite conference on September 1979 to discuss the issues of nursing and other health personnel.

4. National Tripartite Conference on Employment and Conditions of Employment and Conditions of Life and Work of Nursing and Other Health Personnel Joint Communique, September 29, 1979, Manila.

5. 1973 Philippine Constitution.

6. Labor Code, PD 442.

7. Brownlie, I. Ed., "Universal Declaration of Human Rights", *Basic Documents on Human Rights,* London: Clarendone Press, 1971.

8. Agagan, Cresencia, "The Problem of Unemployment of Nurses in Metro Manila: Extent, Causes and Implications: National Defense College of the Philippines, 1980.

CHAPTER 3

Rationalizing Drug Policies in the Philippines

Michael L. Tan

During the "people's power revolution" in February, an urgent appeal was aired over radio for drugs. Four specific items were named: Lipovitan, Yakult, Chlorostrep and Lomotil.

That appeal is a sad reflection of the results of irrational drug policies in the Philippines. It shows, among other things, the addiction our people have developed to certain brand names, and the unawareness we have of useless as well as dangerous drugs. We shall return to those four drugs later in this paper, to show why we need rational drug policies. But first, we need to define what we mean by rational drug policies.

Drug policies are those formulated and implemented by the State, in coordination with the pharmaceutical industry, health professionals and the consumers, to regulate the production, distribution and consumption of pharmaceuticals. We are therefore talking about a wide

range of policies, a complex and vital, if not volatile, issue, which ultimately boils down to consumer protection. In other words, drug policies are rational when they have consumer welfare as its ultimate objective.

What is the situation we have today in the Philippines? Drug policies are, to say the least, haphazard and confusing. In some areas regarding production and use of pharmaceuticals, policies are completely non-existent. Let us look at some concrete manifestations:

TOO MANY DRUGS

It cannot be denied that we have too many drugs in the Philippine market. There are an estimated 9930 drug preparations flooding the Philippine market today. [1] These would include only the registered drugs, excluding herbal preparations and other products from fly-by-night operations. Whatever the real figure is, we can say that there are at least a thousand different drugs available, singly or in combination.

How many of these preparations are essential? It is difficult to say, but the World Health Organization has an Essential Drugs List with about 210 items, which are said to be adequate for about 90% of ailments. [2]

There are many problems associated with this proliferation of drugs in the market. For one thing, it is hard to imagine our Bureau of Food and Drugs keeping track of all these drugs and insuring quality control. On the part of physicians, even someone with a photographic memory would not be able to remember even a fourth of the names of these drugs. And of course, for the consumers, there is absolutely no way of becoming familiar with even a hundred of those drugs.

What has caused this avalanche of drugs on the local market? We have, foremost, the problem of brand-name proliferation. For paracetamol (acetaminophen) alone, we have at least 42 brand names listed in the Philippine Index of Medical Specialties (PIMS), excluding preparations that combine acetaminophen with other analgesics or other pharmaceutical ingredients. It also excludes some common proprietary brand names such as Medicol and Biogesic. Neither does it include the two most recent introductions to the local market: Panadol and Zolben. (Table 1)

TABLE 1

BRAND NAMES OF PHARMACEUTICAL PREPARATIONS IN THE PHILIPPINES CONTAINING PARACETAMOL (ACETAMINOPHEN)
(As listed in PIMS, December 1985)

Aceferin	Napalgin
Acetadol	Naprex
Aeknil	Naprinol
Afebrin	Nasadrin Syrup
*Aminofebrin	*Neo-Beserol
Anapyrin	*Neo-Bromexan Forte
Baropyrin	*Norgesic
*Bentylgesic	Nupyrine
*Bioseran	Octagesic
Calpol	Opigesic
Celparmol	*Ornex
Cherrypyrene	Pacigesic
*Coldenal	*Parafon Forte
Comtrex	Phenogesic
*Congestril	Pinpres
*Coplexin	Pyretal
*Crocin	*Relagesic
*Decolsin	Rexidol
*Dextricyl	Reximed
Dolexpel	*Sangesic
*Dologesic-32	*Saridon
*Drinus	Sumagesic
*Eldepan	Tanpyrol
*Endecon	Tempra
*Febs	*Temprafen
Fever Pain	Teramol
Flugetan	Therapyrine
*Gardan	*Thomapiril
Gendol	*Toplexil
Higesic	*Trind-DM
*Lagaflex	*Tuseran-Forte
Lenor 500	Tylenol
*Meracoid	*Unigesic
Metagesic	Unilab/Paracetamol
*Mucotuss Forte	Valadol
Nafarin A	Winadol

*Contains other therapeutically active components, besides acetaminophen.

With so many brand names of paracetamol on the market, why has the Bureau of Food and Drugs allowed the registration of new preparations? There is nothing in Panadol, introduced last year by Sterling Drugs, which cannot be found in other paracetamol preparations. As for Ciba Geigy's Zolben, its soft gelatin preparation supposedly gives faster pain relief. I realize times are hard and instant relief is something everyone is looking for, but let us not forget that Zolben costs ₱1.80 per capsule, about four times more expensive than "regular" paracetamol preparations.

This takes us to the point of cost. There is significant variation in the prices of different brand names. Using paracetamol as an example, we have the following extremes for particular brand names:

Brand Name	Price/tablet or capsule
U/L Paracetamol (500 mg)	.30
Panadol (500 mg.)	.50
Biogesic (500 mg.)	.55
Winadol (500 mg.)	.60
Rexidol (600 mg.)	.70
Tempra (325 mg.)	.70
Zolben (500 mg.)	1.80

What would a physician prescribe, or what would a consumer decide while looking at the bewildering variety on the counter? Naturally, it would depend on exposure to promotions: for the physician, the drug literature distributed by pharmaceutical firms, and for the patient, the mass media barrage. How many people, for instance, are aware of the existence of paracetamol preparations such as Aeknil, Dolormin or Higesic? These are produced by the smaller companies, who have no budgets for advertising and therefore have smaller shares in market sales. The advantages come with advertising budgets and not necessarily with efficacy or safety. Panadol, for instance, is produced by a multinational firm, which can afford to produce an advertisement with multilingual endorsements to project its alleged worldwide popularity. Who would not be impressed, unless one can tell it was terrible French they used in one portion of the ad.

Brand name proliferation is associated with the phenomena of 'me-too" preparations constantly being introduced into the market. These are preparations which are essentially similar to those already existing in the market, but which have slight modifications in the number of milligrams, or in the addition of ingredients that may not

necessarily enhance efficacy of the preparation. In some cases, the "me-too" preparations may actually resort to irrational, if not dangerous, combinations just to look different.

Let us take Lipovitan as an example. Lipovitan is a "pep drink" – I am not sure if it is even registered as a drug. This tonic is one of the many vitamin preparations on the market. Vitamins, in fact, represent the second largest group of imports among pharmaceuticals, second only to antibiotics. How much of these vitamins are truly essential? The World Health Organization's Essential Drugs List only includes a few vitamins as antianemia drugs and for specific therapeutic needs; but we find on the market multi-vitamin and mineral preparations containing everything, as the ad goes, from "A to Zinc".

There is now worldwide concern, among consumer groups, over the indiscriminate promotion of vitamins as a substitute for better nutrition. In the case of Lipovitan, we find here an even worse case of a non-essential for Lipovitan is nothing more than 50 mg. of caffeine with vitamins, and citric acid as flavoring. The tonic costs ₱14.50 for a 100 ml. bottle. Another similar preparation, Revital, costs ₱8.25 for the same amount, with almost exactly the same ingredients except that it adds malic acid. Catering mainly to men, with strategic advertisements in the newspapers' entertainment page alongside ads for sauna baths, the money spent for Lipovitan could be put to better use buying nutritious foods for the family and if the man needs it, coffee.

Other non-essential drugs which account for a significant percentage of pharmaceutical sales in the country are cough and cold preparations and anti-diarrheals.

The World Health Organization cites only one item for diarrhea: oral rehydration salts, which can even be prepared at home using water, sugar and salt. Yet, the section on anti-diarrheals in PIMS is one of the longest, listing all kinds of anti-spasmodics (such as Lomotil), adsorbents and the like. The industry even has its own version of oral rehydration salts, which are much more expensive that the Oresol available for free from the Ministry of Health.

Of even greater danger are the many antibiotics used by the public for the simplest of diarrheas. Based on our community surveys, the most frequently abused are chloramphenicol (e.g. Chloromycetin) and the combinations of chloramphenicol and streptomycin (e.g. Chlorostrep, Dostrol). Both antibiotics are supposed to be prescription drugs because of their potential adverse effects. Moreover, their use even in infectious

diarrheas is highly questionable since there are other antibiotics of choice for cholera, shigella, amoebiasis and giardiasis. A recent article by a noted expert on childhood diarrheal diseases states that the most commonly used drugs for diarrhea, including such innocuous substances as kaolin and pectin (Kaopectate), "is not only a national waste of time and money, but also harmful to the patients, and may prolong the diarrhea or cause toxic side effects." [3]

There is now enough consensus among expert pharmacologists that cough preparations are unnecessary except in cases where the cough becomes excessive, interfering with day to day activites, and where it is non-productive. [4] But so many of our cough preparations actually combine a cough suppressant with expectorants, an irrational mixture. Others add ingredients for which there has been no proven value. The popular Benadryl as with a number of other cough preparations, actually use antihistamines which have the potential of becoming abused, as we have recorded with drug dependents in Manila and in the provinces.

Cold preparations are often similar to the cough mixtures, combining antihistamines to dry up the mucous membrane with a cough suppressant, an expectorant, and an analgesic to handle the cold's fever and muscle pains. Again, most physicians know very well that there is no cure for the common cold, since it is viral in origin. Yet, the cold preparations continue to be promoted and prescribed, sometimes with antibiotics.

TOO LITTLE INFORMATION

Reference has been made to the problem of antibiotic abuse. Antibiotics, and steroids, are becoming too popular as "shotgun remedies" which bring dramatic, but often misleading, signs of recovery in patients. But there is too little information available to health professionals and the public on the rational use of these drugs. Only recently, there was a newspaper article on a physician who had administered Penstrep injectable, another combination dose banned in many countries, to a child in 1979. It turned out the child was allergic to penicillin and died after receiving the drug. A case filed against the physician for neglect, because he had not given a sensitivity test, was dismissed because an allergy specialist testified that there is, as yet, no reliable test for penicillin sensitivity. [5] The point is, a sensitivity test should still have been administered: this has been in pharmacology textbooks for the last two decades.

The indiscriminate use of antibiotics by physicians is easily transferred to the patient. It should not be surprising, the, that we have more problems with antibiotic resistance. For instance, we have the world's second highest rate of supergonorrhea strains (after Thailand). Who knows about our other diseases – the growing rates of typhoid for instance could probably be associated with super salmonella strains.

Or, let us look at tuberculosis. Isoniazid (INH) is probably the most abused anti-infective drug in the country. A child is only too easily diagnosed as having "primary complex" and is given a standard dose of INH under one of its many brand names As a result, INH resistant cases of tuberculosis are now a problem in the country, and we sometimes have to resort to using as many as four different drugs, including the extremely expensive rifampicin (@₱12 per capsule).

The abuse of INH has other dimensions. Physicians may prescribe a brand name of INH, which often combines vitamin B, telling the mother that this is "to strengthen the child's lungs". Thus, in our urban poor communities, we find mothers using INH as a vitamin because of that advice given by the physician. Over the week-end, I checked out Mercury drugstore in Cubao and found them selling Odinah and Trisofort over the counter, side by side with cold remedies. I would like to point out that these two brand name preparations of INH have been mentioned by drug dependents as easily available, and cheap sources for getting a high. None of them were aware that in excessively high doses, INH causes convulsions, which may be fatal.

This may sound excessive but it seems we have developed a drug-dependent culture. We fret about the growing number of drug dependents, but may forget members of our own families who are taking 8 to 10 drugs daily, including vitamins to get started in the morning, antacids and digestants following meals, and as night falls, a tranquillizer. Children and older patients are particularly susceptible to over-prescribing habits of physicians. Appetite stimulants of still unproven efficacy continue to be popular, an irony for many low-income families since even if the stimulants work, there is nothing to feed the child. So-called growth stimulants are actually anabolic steroids, with known adverse side-effects for children.

Other newer problems are so-called natural remedies such as Bee Pollen, dismissed by Bangladesh's Zafrullah Chowdhurry (1985 Ramon Magsaysay Awardee for community service) as "multinational honey" and Yakult, which is just glorified yogurt. Geriatric preparations with

ginseng and hormones are also heavily advertised, catering to those going through mid-life crises about their potency. There is simply too much manipulation of the consumers.

What alternative sources of information are available for the public, or even for the physician? Package inserts are rarely given to the consumer, especially those who buy the drugs on the "tingi" system. Even when one purchases 10 tablets of an over-the-counter drug, you don't even get the ingredients listed on the package, as I have found for such popular over-the-counter preparations such as Medicol, Cortal, Decolgen and similar preparations.

The Philippine Index of Medical Specialties is the standard reference for physicians but this is produced by the pharmaceutical industry, providing capsulized information, which tends to play up indications while reducing the number of side-effects, contra-indications and special precautions.

We mortals depend on the physicians for information on rational drug use, but the physician is in turn often too dependent on information supplied by the industry. In other countries, there are independent drug bulletins and announcements from national drug regulatory boards about adverse drug reactions and other problematic pharmaceuticals. We have too little information, and our drug regulatory authorities are too quick to allow the introduction of new drugs, too slow to withdraw those which have become problems in the developed countries. How many physicians, for instance, are aware of the brewing controversy over the anti-rheumatic drug Feldene (piroxicam) in the United States and Europe because of an alleged association between its use and gastrointestinal bleeding, including fatal cases, among patients aged 60 and over? [6] Is it mere coincidence that Pfizer launched a media blitz not too long ago about the need to listen to the doctor and to get rid of "old fashioned remedies for rheumatism"?

How many of our people are aware that last year, Ciba-Geigy voluntarily stopped production of its brand name preparations of oxyphenbutazone (Tanderil and Tandalgesic) but that other companies continue to produce and sell their brand names such as Arthrazone, Reozon and Rodaril? Ciba-Geigy also decided to revise their package inserts to limit the use of phenylbutazone (Butazolidin) but the other companies continue to distribute their products, such as Alaxan, Nortaludin, Pyrazon and Skelan Forte, with inadequate warnings. Following Ciba-Geigy's commendable show of corporate responsibility, we sent a letter to the Bureau of Food and Drugs asking what action they intended to take on the other brand names of these butazone preparations.

There was never a reply. In February, I visited the BFD to ask for copies of their administrative orders on various drugs. After being referred from one person to another, all extremely arrogant, I ended up in their library, which had a very incomplete file.

One last example, Ortho Pharmaceuticals has stopped producing its intra-uterine device, the Lippes Loop, and has sent letters to US physicians about their decision, as well as revised versions of their product information, indicating very clearly the risks of primary infertility associated with the use of IUDs in general. [7] Has a similar move been made here?

THE EFFECTS OF IRRATIONAL DRUG POLICIES

Our discussion, so far, focuses on too many drugs, too little information. This situation is due to the lack of clear, rational national policies on drugs. What are the effects of such deficiencies in policies?

More drugs on the market have not meant a healthier nation. On the contrary, it has meant increased costs for the consumer, and the irony is that more Filipinos are losing access to essential drugs, while spending for non-essential ones. Working in urban primary health care, one can see this very clearly. In the shadow of Mercury drugstores, one finds families spending for cough syrups and vitamins to treat tuberculosis and malnutrition. In rural areas, the problem is even worse – no drugs at all, except for the few dole-outs marked MARCOS (Medical Assistance to Rural Communities and Other Sectors).

The problem is not just one of cost, but of actual availability. Despite the endemic nature of malaria in the country, it is hard to find quinine, which incidentally is not even listed in PIMS. I realize the side-effects associated with quinine, but the newer drugs also have their problems, including cases of resistance.

It is clear that the industry caters to a small percentage of the population. Although its sales seem large in absolute figures of about ₱5 billion, this computes to about ₱90 per Filipino, a figure representing an average between high-income families spending ₱3000 per month for drugs and others, not having anything to spend at all. Everyone is aware of how medical emergencies can force even middle-income families into huge debts just to pay for drugs.

STRUCTURAL PROBLEMS

The high costs of drugs are said to be due to production. A more accurate way of putting it is to mention the high costs of importation and marketing. We import 95% of raw materials, and our industry is mainly one of processing bulk importations into dosage forms. Just what are we importing? Nearly everything, it seems, down to the cotton wadding and the packaging materials. The bill for importing medicinal and pharmaceutical products was $61.1 million in 1984 and $75.9 million in 1983. [8] This excludes importations of fruit flavorings, essential oils and other organic and inorganic chemicals, as well as packaging.

Our problem is not just dependency on imports, but the almost total reliance on foreign technology. We still do not have figures on how much we spend for such technology and for the patents, royalties and expenses for foreign consultants.

The fact is that the drug market is controlled by a few companies. One company alone, United Laboratories, controls from 20 to 25 percent of the market. The history behind United Laboratories is well-known by now – it is owned by Jose Y. Campos, a known Marcos crony, who recently admitted that he was used by the deposed dictator as a front for many business deals. Campos, incidentally, has substantial shares in other large drug companies such as Medichem and Pediatrica. Campos even has shares in G. D. Searle. A sister company of United Laboratories, Chemfields, turns out to be 60% owned by Marcos through 3 front companies. [9]

Another 60% of market sales is accounted for by 18 multinational companies, mainly U.S. and European. (Table II) The rest of the market is divided among more than 200 other companies, mostly small Filipino-owned firms. The above figures should be analyzed more deeply, however, for even United Laboratories' sales would include products manufactured for other multinational companies such as Imperial Chemical Industries (ICI), Beecham and Schering. The share of multinationals in the market would therefore be at least 70% and possibly as high as 90%.

Such structures spell powerful political influence in terms of lobbying. It is well known that the Drug Association of the Philippines, composed of the larger multinational companies, was able to block the implementation of a presidential decree in the late 1970s that would have allowed for some transfer of technology and help to break the crippling dependence we have on foreign companies.

TABLE II

MARKET SHARE OF THE LARGEST DRUG MANUFACTURING AND DISTRIBUTION FIRMS IN THE PHILIPPINES (BASED ON 1984 SALES)

	MARKET SHARE
1. United Laboratories (Fil.)	25.0
2. Bristol Laboratories (U.S.)	6.5
3. Warner Lambert (U.S.)	5.4
4. Abbott Laboratories (U.S.)	4.7
5. Zuellig Pharma (Fil.)	4.6
6. Wyeth-Suaco Laboratories (U.S.)	3.7
7. Pfizer Laboratories (U.S.)	3.6
8. Ciba Geigy (Swiss)	3.4
9. Richardson Vicks (U.S.)	3.3
10. Boehringer Ingelheim (W. Germany)	3.0
11. Sterling Products (U.S.)	2.8
12. Roche (Swiss)	2.5
13. Filipro Nestle (Swiss)	2.5
14. Cathay Drug (Fil.)	2.2
15. A.H. Robins (U.S.)	2.2
16. E. R. Squibb (U.S.)	2.1
17. Cyanamid (U.S.)	2.1
18. Astra (Swedish)	2.1
19. Merrell Dow (U.S.)	2.0
20. Glaxo (British)	2.0

SOURCE: IMS figures as reported in Business Day, 2-4-85

In terms of prices, drugs were one of the first group of commodities to be excluded from price control several years ago. The companies have continued to resist appeals to reduce drug prices. Sound business sense seems to have intervened last year when they reduced, by an average of 5%, the prices of some drugs. I say "sound business sense" because at the rate they are going, they are outpricing themselves out of the market. DAP member companies have been posting increases in the peso value of drugs sold in the country from 1980 to 1984, but in terms of unit sales, the increases have been much lower, and in fact decreased in 1984. (Table III) Profitability ratios remain healthy,but this situation cannot continue without more price increases, at the expense of the consumers.

TABLE III

DRUG SALES OF SELECTED DAP MEMBER COMPANIES, 1981-1984

YEAR	PESO SALES (BILLIONS)	% GROWTH	UNIT SALES (MILLIONS)	% GROWTH
1981	3.305	18.1	132.264	7.7
1982	3.715	12.4	135.700	2.5
1983	4.374	17.7	140.572	3.6
1984	5.337	22.0	120.089	(14.6)

SOURCE: DRUG ASSOCIATION OF THE PHILIPPINES AS REPORTED IN Industry Tripartite Council Newsletter, August 1985

TOWARD RATIONAL DRUG POLICIES

We could go on with more examples of irrational drug policies, but this would take an entire book. It would be more appropriate instead to focus on alternatives that can be taken. These alternatives are based not just on theoretical brain-picking among academicians, but on actual experiences in other countries, both in developed and underdeveloped countries. Some of these recommendations have been proposed five or six years back, but have apparently fallen on deaf ears. For those of us working with primary health care programs, we feel the urgency of the need to take action soon.

1. Adopt a National Essential Drugs List (EDL).

In 1983, shortly after the Aquino assassination and the precipitation of the economic crisis, the Ministry of Health announced it was drawing up an essential drugs list, the items of which would be given priority for foreign exchange releases to drug companies. The industry immediately protested, and hinted that adoption of such a list would result in the disappearance of drug supplies from the market. The industry also said that the EDL would deprive people of other drugs they needed. This is typical sophistry. The fact is that people are presently deprived of the drugs they need, precisely because there are no priorities set for drug procurement and production.

The EDL was never released. Insiders said the original listing of 170 items grew to 440, while the industry wanted 1700 items. Inquiries on the EDL have remained unanswered since the middle of 1984. [10]

The EDL is meant as a guide, to give priority to drugs which a particular country needs most. It is also based on proven efficacy and safety, and would exclude irrational drug combinations and hazardous drugs.

With the adoption of an EDL, which does not necessarily have to be exactly the same as the one produced by the World Health Organization (WHO), both government and private agencies can determine where they can use their scarce monetary resources. An insurance scheme, for instance, could limit itself to reimbursements only for essential drugs. Or government could offer a subsidized scheme limited to essential drugs. So many of the government charity medical missions have actually spent money for useless cough and cold remedies, creating dependency on the part of the public.

The industry has asked that the government reduce taxes on importation of drugs. Perhaps exemptions or reduced taxes could be given for these essential drugs, if of course the companies can assure a reduction in prices of these items. Price monitoring schemes should be adopted to check on these essential drugs.

2. *Encourage the use of generic names; limit the registration of new brand names and "me-too" drugs.*

It would be to the advantage of the public for the State to encourage physicians to prescribe generic drugs. Of course, the problem is that only United Lab and Rhea Pharmaceuticals carry a generics line. Other companies could go into similar lines. A compromise is to allow companies to attach a prefix before the generic name to indicate the company, e.g. UL-Generics for United Laboratories.

Drug companies claim that there are differences among brand names, particularly in terms of "bioavailability". If this is the case, then let us have independent tests conducted to show the differences. This is in the interest of free enterprise and fair competition.

The proliferation of brand names, and me-too drugs, is medically unsound. It causes confusion among health professionals and consumers. And it jacks up the cost of therapy, when a physician prescribes a more expensive brand name simply because that is the only one he has heard of, courtesy of the many drug representatives dispensing free samples.

3. *Strengthen national drug regulatory authorities to insure consumer protection.*

There are, at present, two drug regulatory authorities: the Bureau of Food and Drugs and the Dangerous Drugs Board. Despite our rather unpleasant experiences with BFD personnel, we can understand that they work under great pressure. The BFD budget for 1985 was a measly ₱5.8 million while the DDB only had ₱13 million. Besides that, the BFD has been working with antiquated equipment and its library is obviously deficient in terms of technical references that they need. It is encouraging that a new BFD laboratory is being set up. We hope that no strings have been attached with the foreign assistance extended to construct the new facility and that quality control of pharmaceuticals will improve when the new laboratory is operational.

I would point out that there is no lack of laws and regulations on quality control and on the distribution of pharmaceuticals. Checking through BFD's library files, I actually found old administrative orders dating back to the 1970s, imposing strict regulations on the registration of new brand names, almost tantamount to adopting a generics policy. Why have these remained unenforced?

With regard to the "banned drugs" issue, the United Nations' list of products banned or regulated in different countries [11] lists a significant number of pharmaceuticals allegedly withdrawn or placed on prescription status by the Philippines' drug regulatory bodies; but again, enforcement has been weak. The BFD and the DDB need to be given more "teeth" to enforce regulatory laws.

4. *Provide independent and objective information to health professionals (including pharmacists) and the general public on the rational use of drugs.*

Both the public and private sectors need to start providing alternative sources of information on drugs. We still do not have our own National Formulary. If this cannot be produced, drug data sheets could at least be provided and disseminated through professional groups and the mass media. These should be produced by independent groups. The now defunct TAFDA (Technical Advisory Committee for the Food and Drug Administration) within the Ministry of Health should be restored – the integrity of that body was well-known and it is still a mystery why it was dissolved.

What do we mean by independent and objective information? This includes accurate information on efficacy and safety of drugs, including possible side-effects and precautions that need to be taken. Other countries have independent drug bulletins produced by consumer groups, using expert authorities. We have access to these bulletins, and have tried our best to get to the government whenever we receive news on problematic drugs, but rarely have we been listened to. The mass media, in turn, rarely picks up these issues, perhaps because of the advertising revenues that may be lost from the drug industry.

Complementing independent drug information should be stricter regulations on advertising and marketing practices of drug companies. There should be conformity with 'truth in advertising' guidelines, whether in print media or in the promotional materials given to physicians. Let's face it, we face patent cases of outright deception when drug companies claim that their product is good for a range of ailments from "impotency to guilt and anxiety."

Other countries have a "Dear Doctor" system through which drug companies can show corporate responsibility. This system entails the drug companies sending out letters to all physicians whenever they start receiving reports of adverse reactions or other problems with their products. Unfortunately, a double standard operates wherein the letters are sent only to doctors in developed countries, even if the same problematic product is sold in the Third World.

Action on a law to regulate the marketing practices of infant formula manufacturers should also be given priority, as soon as a new parliament can be convened. If the penal provisions against physicians are the main cause for concern, then at least discuss these but a resolution should be made as early as possible.

Revisions in medical and nursing curricula are also drastically needed, to wean our future professionals away from a drug-fixated approach to disease. Primary health care programs also need to strengthen education of community health workers on the rational use of drugs. Finally, a program of consumer education is necessary. All these campaigns can involve non-governmental groups, academic institutions and the mass media.

For a more immediate goal, we urge the Bureau of Food and Drugs to be more open and courteous to public requests for information. If there is sensationalism on the banned drugs issue, it is because the

Bureau has been so closed to inquiries even from academic researchers. How can we be expected to provide objective information to journalists unless the Bureau cooperates?

5. Initiate steps toward self-reliance in pharmaceutical needs.

All the measures above would be palliative unless we take steps tc break away from our dependency on multinational drug companies.

The development of medicinal plants has been advocated as one step. But we should recognize the limitations of medicinal plants. It will take several years before we can extract active ingredients from these plants for particular therapeutic uses. In the meantime, our people need access to drugs such as antibiotics.

Other underdeveloped countries, notably Bangladesh, have shown the way, by adopting stricter policies on technology transfer, on the introduction of new drugs, and even on the production of drugs. State-owned or private, we need to have a pharmaceutical manufacturing firm that will produce essential drugs at low cost. It is a myth that large capitalization is needed to produce drugs. Gonosthasaya Kendra, in Bangladesh, started its now famous pharmaceutical firm with an initial capitalization of less than $4 million. They are able to produce most essential drugs, including antibiotics, and to provide these at costs up to a fourth of that from multinational companies. It is also a myth that multinational companies alone can insure quality control. Pfizer was recently reprimanded by the Bangladesh government for lapses in quality control and Ciba-Geigy had similar problems in Japan. [12]

The drug industry here says that due to economies of scale, we cannot go into our own direct manufacturing of drugs. Granted this is the case, since most Filipinos are too poor to buy the drugs, then we should at least have one independent and incorruptible pharmaceutical firm that can bid on the open market for raw materials, to import these and package them into dosage forms at prices that will surely be competitive with those of other companies.

To overcome problems of economies of scale, cooperation among ASEAN countries has been proposed, but this has not been developing as rapidly as it should. With this system, the ASEAN countries could divide up essential drugs, each country producing enough for the entire region.

CONCLUSION

Rationalizing drug policies is a multisectoral task that must involve government, industry, non-governmental health groups, the private health sector, and the consumers. It will not be easy to achieve consensus, since interests tend to conflict, however, the signs are clear that all over the world, there is growing consciousness about the need to rationalize drug policies and, in a more general sense, to rethink our existing approaches to health care.

In our part of the world, a campaign called ARDA (Action for Rational Drugs in Asia) has been launched by the International Organization of Consumer Unions (IOCU), involving 8 countries. Meeting recently in Penang, delegates expressed hope that with the restoration of a democratic government in the Philippines, efforts will be taken toward formulating policies that will insure accessibility of Filipinos to drugs at low cost, without compromising quality. We must face up to this challenge.

FOOTNOTES

1. Figures from Dr. Nelia Cortes Maramba, cited by Aurora Parong, "Essential Drugs for the People", *Medical Action Group Bulletin*, January-March 1986, p. 28. In an article in *Bulletin Today*, January 16, 1984, Maramba said that some 3,000 generic drugs were being sold in the country under an estimated 15,000 brand names. In June, 1985, the Bureau of Food and Drugs said it was trimming down the brand names to 8,447 *(Bulletin Today, June 21, 1985)*.

2. *World Health Organization*, The Use of Essential Drugs, *4th revision. Technical Report Series No. 722. Geneva: World Health Organization, 1985.*

3. Billoo, A. Ghaffar. "Infantile Diarrhoea: Management with Oral Rehydration". *Medical Progress*, February 1986, pp. 15-24. Also see World Health Organization, *A Manual for the Treatment of Acute Diarrhoea.* (Geneva: World Health Organization, 1984)

4. "Cough Medicines", *Drug and Therapeutics Bulletin*, November 4, 1985, pp. 85-87.

5. *Bulletin Today*, December 9, 1985.

6. On the controversy over piroxicam, see *Scrip*, January 10, 1986, pp. 11-13. A case has been filed by the Washington-based Health Research Group to have the US Department of Health and Human Services to restrict the use of the drug. (Letter from Dr. Sidney Wolfe to the Secretary of the US Department of Health and Human Services, January 8, 1986.)

7. "Manufacture of Lippes Loop Discontinued" and "New Labelling for Remaining Lippes Loops", *Outlook* (Program for Appropriate Technology in Health, Washington, D.C.), January 1986, pp. 8-10.

8. *Foreign Trade Statistics* (Manila: National Census and Statistics Office, 1985).

9. *Business Day*, April 4, 1986.

10. During the open forum, drug industry representatives explained that the increase in the number of items in the proposed EDL for the Philippines was not due to industry lobbying but to recommendations made by various medical specialty groups.

11. United Nations Secretariat, *Consolidated List of Products Whose Consumption and/or Sale Have Been Banned, Withdrawn, Severely Restricted or Not Approved by Governments*, July 1984.

12. Speech of Dr. Zafrullah Chowdhurry sponsored by Ramon Magsaysay Memorial Foundation, September 1985, and personal communications, March 1986. The Ciba Geigy case is cited in *Japan Times*, December 28, 1985, where the Japanese government ordered the company to suspend manufacturing and sales of its products for 20 days, following discoveries of falsification of data in applications seeking authorization for the production and distribution of 46 of its products. Ciba Geigy eventually issued a press release regretting the irregularities.

Open Forum

Dr. Esperanza Cabral, head of the pharmacology department of the University of the Philippines, gave the keynote address, during which she revealed the existence of Executive Order 776, issued by deposed President Marcos, requiring drug companies to purchase antibiotics from a "known crony firm" (Chemfields) at prices three times above that of the world market.

During the open forum, opinions clashed anew as drug industry representatives met with non-governmental groups and professional organizations. A heated debate rose over the issue of nationalization of the drug industry, although it was not included in the list of recommendations.

Katipunan de los Reyes, president of the Drug Association of the Philippines (DAP) and manager of Sandoz, said that nationalization would be "criminal".

"We will just be showing our weakness. . . it speaks ill of us if we nationalize," he said. De los Reyes proposed that Filipinos divest from "monkey business" and sink their money into a local drug manufacturing firm that will compete with the multinational drug companies (MNCs) that are said to dominate the industry.

Dr. Romeo Quijano, professor of phamacology at the University of the Philippines, argued that while nationalization remains "impractical" for now, it is a necessary step to be taken if the country is to realize self-reliance. He clarified that nationalization would not mean slamming the door on the MNCs, especially for those drugs which the country has no capability of producing.

On the issue of generics, De los Reyes said the pharmaceutical industry is "not against the adoption of generics but against the banning of brand names." The two lines, he maintained, should coexist to give consumers and health professionals free rein on what to use and what to prescribe.

Regarding the issue of an Essential Drugs List (EDL), which the health ministry began working on in 1983 but never released, de los Reyes said that the "jacking up" of the number of items on the proposed list was not due to the drug industry's lobbying, but was the effect of recommendations made by various medical specialty groups consulted by the ministry.

Dr. Michael Tan, the lecturer, said that a national EDL is meant to serve as a guide on how scarce resources could be used, by both private and public sectors engaged in drug procurement. He said this list does not have to be exactly the same as that of the World Health Organization since each country has its own peculiar needs.

Dr. Ed Clemente of the Capitol Medical Center, brought up the issue of transfer pricing, where mother drug companies charge diffeent prices to different countries for the same drug. De los Reyes said that this is true only for a few MNCs, adding that "90 percent of MNCs" get inputs at costs similarly priced in other countries. De los Reyes said that drug manufacturing firms must operate on profits not only to maintain costs but because "if we don't, the government looks at us with great suspicion."

Benjamin de Guzman, past president of the Drug Association of the Philippines (DAP), argued that the number of drugs in the market should not be limited. He said that consumers always have their options.

This drew a sharp retort from Dr. Carolina Araullo of the Council for Primary Health Care, who asserted that consumers rarely enjoy this option since they are "uninformed, misinformed, and systematically disinformed."

Task Force representatives stressed the need to popularize the rational use of drugs, and this process would have to start with health professionals reeducating themselves.

Both non-governmental organizations (NGOs) and the drug industry representatives agreed that drug regulatory authorities, such as the Bureau of Food and Drugs, should be strengthened. De los Reyes said that the foremost problem of the industry is the proliferation of fake drugs.

The NGOs urged the members of the drug industry to exercise corporate responsibility, more so in producing accurate information on drug efficacy and safety. DAP representatives said that NGOs can approach the DAP for general information needs, but that individual drug companies have their own policies on responding to inquiries.

CHAPTER 4

Community Health Financing

Antonio Perlas

First, I would like to start out by clarifying that my comments today are not made in behalf of the Ministry of Health.What I will be describing will be aspects of a community health care financing scheme, based on a study with the Philippine Council for Health Research Development (PCHRD).

Our project has been looking into projects, emphasizing the component of self-financing. The following table gives the types of community financing that are possible.

TYPES OF COMMUNITY FINANCING

1. Service Fees
2. Drug Sales
3. Personal Prepayment
4. Production – based prepayment
5. Income-generating schemes
6. Community Labor
7. Individual Labor
8. Donations and Ad Hoc assessments
9. Festivals, raffles, and similar activities

Some of the above possibilities should be explained. *Personal prepayment* schemes include halth insurance and health maintenance organizations (HMO). *Product-based prepayment* schemes would be

take-offs from other projects such as agricultural cooperatives, which could allocate part of its resources to finance social services. This is being done at present by groups such as LIKAS. Similarly, *income-generating projects* could also set aside part of its funds for health financing. This could be done, say, from KKK projects, as a supplement to Medicare.

OPERATIONAL PROBLEMS RELATED TO COMMUNITY FINANCING

1. The role of the community
2. The objectives of community financing
3. Linkages to other financing of primary health care
4. Contributors to and beneficiaries of community financing
5. Services and commodities to be financed
6. Revenue mobilization methods
7. Prices, fees and changes
8. Training and education
9. Management and Administration
10. Payment and Revenue collection
11. Supervision and control
12. Monitoring and evaluation of community financing performance

Any project would have operational problems. In the context of community health financing schemes, many of the problems, as named above, are obviously related to the level of community organization, which I have further outlined below. These issues are the criteria used in approving project proposals for health financing schemes.

SOME ISSUES IN THE APPROVAL PROCESS OF THE MANAGEMENT COMMITTEE

1. Following the Primary Health Care Level of Development, the Committee believes that the Community should have at least gone beyond Level 2 (organization)

2. Corollary to No. 1, the proponent should have had actual experience in health care delivery. It should be emphasized that an income-generating component in proposed projects must always be subservient to the delivery of health services.

3. The need to finance activities involved in creating a social preparedness to increase the likelihood of success of the project. This is to

address the spirit of the project. The costs entailed in social preparation should be seen as part of overhead which will not be recoverable. However, it is important to include this since people represent a cohesive force which gives direction to the program. We need to enhance the requirement for the presence of mechanisms that will encourage people to work together.

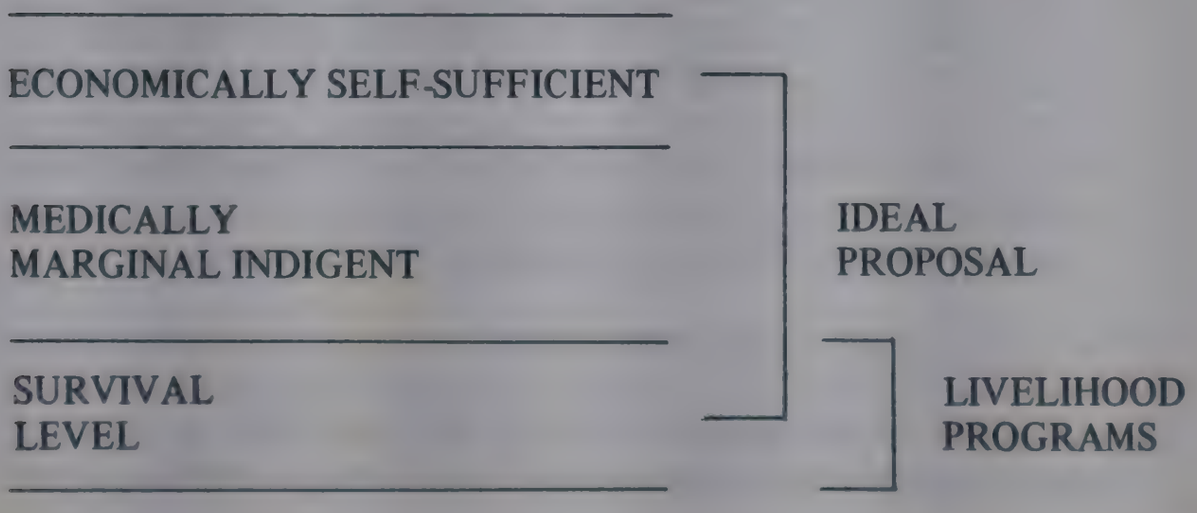
4. Number 3 will entail developmental costs which will be reflected in an increase in personnel budget.

5. The phase of social preparation, however, should be accompanied by institution development ultimately leading to a proposal on a health care financing scheme.
   5.1 The question that must be answered, however, is how much money is necessary for the proposed project to progress through each phase.

6. Differentiation between an income generating project and a health care financing scheme. Many projects actually are for income generating schemes, which eventually produce funds for health financing. It may be best, however, not to start a project based on the viability of income generation itself. It would be better to have a previously existing income generating project, which has sufficient resources from which a health financing scheme could take off.

7. Akin to No. 6 is a study of the economic level of the community, since this is critical in determining the feasibility of implementing a health care financing scheme.

COMMUNITY SOCIO-ECONOMIC LEVELS RELATED TO HEALTH



Many groups on the survival level can rely only on livelihood programs. In other communities, we may need schemes to straddle all groups. Those with more resources, including corporations, may help to support or subsidize the more marginalized sectors.

We could also explore the possibilities of merging programs such as Medicare and HMOs. Medicare represents a captive financial resource which should be utilized.

Health financing schemes generally require a large number of participants in order to become viable. We are, for instance, supporting one project through the labor confederation KAMAO, which includes some 11,000 jeepney drivers.

8. Preventive/promotive services must be incorporated in the proposal together with the curative services. The program and source of funds for these are sometimes difficult to ascertain. As much as possible, government should be freed from supporting curative aspects.

9. Linkages with other health facilities specially for secondary and tertiary levels of care should be spelled out.

10. Assume a certain amount of risk and try to correct deficiencies as the project implementation proceeds. We have observed that people tend to drop out on their premium payments. Perhaps it is time to understand people's perceptions of health, including the difference between "important" and "urgent" in terms of priorities.

11. Viability *vs* community participation in proposal making. How viability is to be achieved must be clear in the proposal. Visions of large projects may sometimes be unrealistic given the small net incomes of communities. We have to understand the roles of different sectors. Government is not, at present, in the position to finance these schemes, due to escalating costs. We need to articulate principles of primary health care in relation to community health financing. Pooling of resources should always be considered.

No. 1 is contrary to the position that some proponents have taken that since in order for a project to succeed the community must participate in the decision making, then the kind of financing scheme should be an output of the implementation of the project.

12. The appropriateness of a scheme for a particular segment of the population with its level of social preparation and other conditions. A study on international aid has shown very clearly that the success of projects depends to a large extent on social preparation.

REACTIONS

Dr. Manuel Dayrit

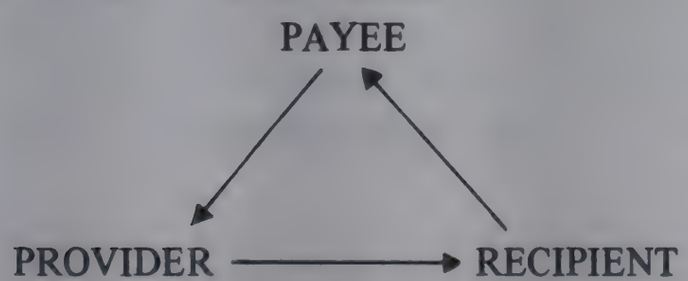
In discussing health financing, I believe we should address two important sets of questions.

The first cluster would include: (1) Who is paying? Private or public sector? Individuals/communities/insurance firms? (2) Can the payee afford it?

Next, we need to consider: (1) Can we keep costs down, while keeping quality up? (2) Can we increase the capacity of the beneficiaries to pay?

There are two possible scenarios in dealing with the above questions:

First, we may have the following scheme:



e.g. prepaid insurance

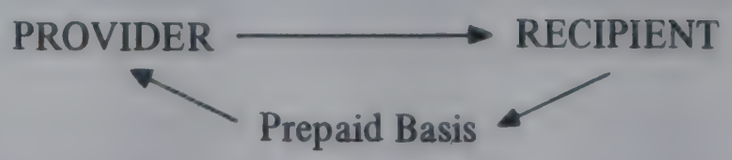
The problem in such a scheme is that the provider has no incentive to keep costs down. For instance, Medicare provides such a low ceiling that providers would charge to the maximum.

In a second scheme, we would have the following:

Fee for Service

This is, of course, the dominant scheme in the Philippines and should, in theory, provide high quality care, but at high cost.

A third alternative would be this:



This would give the health provider an incentive to want to keep the recipient well since the fees are prepaid, regardless of the condition of the recipient during the period where he or she is covered. The problem here is that providers can still "cheat" on the recipients.

There are other aspects of health financing that are constantly discussed. We have the matter of achieving a balance between quality and cost. We have to consider individual needs and community resources. We have to recognize that people tend to think "curative" which easily bankrupts community health funds. We even need to look at the linkages of individual needs to individual resources and to livelihood programs. What is the more acceptable scheme?

On the question of government's role, I believe that the government cans shoulder expenses for public health programs, but not for individual needs. By public health, I would include the provision of safe water supplies, sanitation and vector contro. I agree that we must free the government from shouldering individual for curative services.

Dr. Agnes Quisumbing

I would like to start out by saying that Dr. Perlas' scheme is innovative, at the local level.

Broadening our perspectives, we economists consider health as a public good that should be enjoyed by all. Health has social benefits, subject to externalities. Everyone benefits, but there is a need for government support. In this context, we may need to reexamine the existing fiscal structure, as it applies to health financing.

At present, we have a system where the taxpayer pays to the national government, which in turn allots money to different ministries to render public services. This is an extremely centralized system, and the national government may not always be receptive to needs at the local government level.

A second type of fiscal system would have the taxpayer paying to the local government, which remits part of the money to the national government, and retains the balance for local government needs. This may be a more responsive system than an extremely centralized structure.

A third system leaves the individual to shoulder the responsibilities for health care expenses. It is a direct relationship between the recipient and the provider. However, as I mentioned earlier, health is a public good and you cannot, therefore, expect the individual to shoulder all costs.

Would such a system, involving direct relationships between the individual and the provider, be viable for the poorest of the poor?

I feel our solutions to the dilemmas in health financing lie not just in subsidization of health costs, but in the introduction of a strong re-distribution component in our economic policies, promoting social justice. Health financing schemes themselves should include a redistributive component.

The product-based scheme described by Dr. Perlas is particularly appealing, and will be important in communities with a mixed-subsistence economy. In such cases, mechanisms could be tapped to pool the produce to build up resources. Perhaps a variation of a "Food for Work" scheme could be introduced, utilizing credit points based on production output.

Health financing schemes must be integrated, not just with other social service programs, but also with livelihood programs. There must be good financial management. There must be local autonomy, while at the same time we should recognize the dangers of petty graft emerging in such cases. Therefore, community participation and accountability would be important to minimize such risks of petty graft.

CHAPTER 5

Hospitals Amidst the Present Socio-Economic Crisis

Thelma Navarette-Clemente

Hospitals, just like other business enterprises, are faced today with a formidable host of economic problems, such as: inflation, prohibitive interest rates on borrowed capital, high cost of money, mounting accounts receivables, and dwindling capital reserves. Not only these, recent political upheavals have reflected a radical change in the socio-economic environment of the country brought about by the ravaged economy. The burgeoning population coupled with the declining purchasing power of the peso (Table I) have raised the poverty line of the 54 million Filipinos.

Table I. Central Bank of the Philippines, Dept. of Economic Research, PURCHASING POWER OF THE PESO IN METRO MANILA		
Peso	**Consumer Price Index**	**Purchasing Power**
1972	100.0	1.000
1973	114.0	.8772
1974	152.2	.6570
1975	164.6	.6075
1976	174.8	.5721
1977	188.6	.5302
1978	202.9	.4933
1979	241.1	.4170
1980	266.6	.3750
1982	176.2	.5675
1984, October	318.3	.3142

Everyone is fully aware of the excessive cost of hospital operations. During the past two years alone, a PHA survey showed that more than 70 private hospitals in the country have declared bankruptcy, have closed, or are in the process of being foreclosed by their creditors–the financial lending institutions. We are indeed appalled why many hospitals are in the state of depression or distress. We cannot seem to understand why even in highly urbanized centers, large tertiary hospitals and the more sophisticated medical centers are financially bound.

We are not just in a state of crisis, but also undergoing the process of revolutionizing hospital operations to suit the needs of the growing lower-middle class of our population who can ill-afford the present cost of hospitalization. The question of survival and viability is foremost in the minds of every hospital administrator. All these require timely response and adaptation to the strong demands of our harsh environment.

Considering the options posed by this difficult ambiance, we must apply the exacting principles of good management specifically for the hospital setting as if it were a true business enterprise or a profitable industry. Let us bear in mind the pronouncement of Peter F. Drucker, an international figure in the field of management, that – "it is the performance of management and the managers of our institutions, business and government, society and culture which will ultimately determine our present and our future". The hospital does not like to be called a business or an industry, because they cannot avail of such

tax shields or privileges when it comes to an industry or business. Hospitals like other businesses use the good concept of management or use good planning, monitoring, financial management and personnel management so that they can be productive. In the latest book of Peter Drucker, "Managing in Turbulent Times – A New Guide for Management Today", the state – "in these turbulent times, and in an economic crisis, managers must focus for actions, strategies and opportutnities". They must perceive what they can do, should do, and must do. The primary task of management is to make sure of the institution's capacity for survival to make sure of its organizational strength and soundness, to recognize its capacity to survive difficulties and other adversities, to adopt to sudden change and if at all possible, to avail of new opportunities and to at least make a profit.

Let me state the principal role of the present day hospital as a socio-humanitarian institution:

- to diagnose, treat illnesses, promote health and maintain health
- to participate in the continuing education of doctors and para-medical workers
- to do research
- to do community services

These roles are time-consuming and cost-intensive. And unless the hospital management is acutely aware of them and acts promptly to control them, then the hospital may sooner or later be carried by the high winds of failure.

Let me give you an overview of the factors responsible for this crisis in hospitals:

A. Reasons for cost increase in hospitals itself:

1. Big increases in the salaries and wages of medical and para-medical personnel with the extension of fringe benefits. The number of "productive" hours per worker per year has steadily decreased whereas labor costs have steadily increased.
2. Inflation and economic crisis which it provoked
   - rising cost of equipment, maintenance supply, drugs, construction
   - rising interest on bank loans
   - gasoline, fuel utilities

3. Use of more specific, diagnostic and therapeutic measures
4. Increased medicines per patient especially of the more sophisticated and more expensive kind
5. Increased number and types of laboratory, x-ray, nuclear examinations, scans, etc.

B. Factors responsible for the crisis in hospitals

1. Worldwide financial/economic problems

It is not only the Philippines that has to tighten its belts, this is worldwide. Even the richest nations are having second thoughts about health care when they found out lately that health care is even beyond the capacity of their individual citizens; even government subsidies will not be enough and would require other forms of payors to guarantee hospital expenses.

a. inflation/depression

a.1 Peso-dollar ratio

The dollar continued to increase while the peso continued to decline, as shown in Table I.

a.2 Central Bank and other bank regulations

In the latter part of 1980-83-85 dollars were no longer available for importation. As you know supplies used in the hospital are 95% imported. So people have used the black market for dollar salting and some have even resorted to smuggling. The Phil. Chamber of Commerce & Industry has told us that if smuggling cannot be controlled, drug manufactures and hospital suppliers (importers) will be put out of business.

b. Financial requirements of hospitals

* private/personal funds
* private banks
* government lending institutions: DBP, SSS, PNB, GSIS

b.1 Capital Formation

Because of the humanitarian aspect of hospital work, businessmen and entrepreneurs do not find this type of service as a money-making or a profit-making venture, It is, therefore, very difficult to borrow the needed capital as any feasibility study honestly depicts the true losing picture of "foreclosure", and "for sale ". Hospitals certainly do not attract investors to this business with a very grim future. Most hospitals borrow their capital as the doctors themselves are very reluctant to invest their hard-earned savings in ventures

like these. Rate of interest continued to soar, so that lately the effective rate is 25% and there is 2-5% service charge. If one defaults in payment, the interest being compounded reaches up to 36% per annum. Foreclosure proceedings are easily instituted so that the hospitals are forced to close, offered for sale, or declare bankruptcy. Hospital financing does not enjoy preferential rates compared to fishing, agriculture or transportation. In 1984 up to 1985 interest rates even went beyond 50% per annum and the payment of the pay back was only of a short period, for 1 to 2 years. This cannot certainly apply for hospitals, because no hospital can be on its feet after 1, 2 or 3 years. Not even 5 or 10 years for a few of us.

2. Construction costs

In a survey conducted in the 70s the highest increase in the 10 prime commodities (construction materials) was: 1-energy, 2-cement and no. 8-drugs. Increases in the construction costs like the cement which was ₱2.40 in the late 60s went up to ₱60 + in 1984-85 if not totally unavailable.

3. Importation costs

– Machines (spare parts), Equipment, Supplies, Drugs 95% imported)

Our doctors and paramedical workers are trained to use Western equipment and supplies. Their daily work is dependent on important apparatuses, supplies, etc., so that the hospital surely needed these as capital investment and are supposed to maintain and upgrade their facilities regularly. Especially among the private hospitals, completeness of facilities, the most modern and sophisticated equipment and competency of the medical staff are contributing factors for competitiveness in the quality of patient care that they can offer. Spare parts are scarce, highly priced if not altogether unavailable. The advances in science also dictate that the latest modalities be available to save a life but all of them are very costly.

4. Operational funds

a. Price and rate setting should be with a 'social conscience"

Table II. Rate Setting

Community Costs	Accounting Cost	Financial Cost	Economic Cost
	community health program cost	non-production cost	non-production cost
Basic Production Cost	research orientaion/education cost, etc.	working & plant capital needs	Bad debt & free service adjustment capital needs
direct & indirect costs of producing a service – labor – materials – depreciation – general service cost center costs	basic production cost	basic production cost	basic production cost

Robin Hood style – rob the rich –– 70-80% are medically indigent. They cannot really afford to pay. Because of these we have to have a socialized pricing. The components of the rate setting is shown in the above Table.

b. salaries and wages
c. mounting receivables
   - delayed payments – Medicare/ECC
   - disallowed claims – Medicare/ECC
   - fly-by-night insurances – vehicular accidents
   - fictitious addresses
   - absconding patients
   - emergency cases
   - no deposit law
d. increasing overhead cost – maintenance
   low occupancy rate – 40-50%

5. Public utilities

I. Electricity (for tertiary 180-200 bed hospital utilizing centralized aircon)

Average monthly bill	1974	₱ 35,001.01
	1980	93,835.71
	1985	403,519.92
Increase in average monthly bill from	1974-1980	58,834.70
	1980-1985	309,684.21
Percentage of increase	1974-1980	167%
	1980-1985	330%

II. Fuel and Oil (for tertiary 150-200 bed hospital utilizing centralized aircon)

Average monthly cost	1974	₱ 8,082.00
	1980	15,570.00
	1985	47,830.38
Increase in average monthly cost from	1974-1980	7,488.00
	1980-1985	32,260.38
Percentage of increase	1974-1980	93%
	1980-1985	207%

III. Water bill (MWSS)

Average monthly bill	1974	₱ 5.255.60
	1980	12.259.52
	1985	46.429.11
Increase in average monthly bill from	1974-1980	7,003.92
	1980-1985	34,169.59
Percentage of increase	1974-1980	133%
	1980-1985	279%

IV. PLDT (for tertiary hospital using PABX telephone 15 trunklines with 126 locals)

Average monthly bill	1974	₱ 5,857.65
	1980	10,675.31
	1985	28,999.63

Increase in average monthly bill from	1974-1980	4,817.66
	1980-1985	18,324.32
Percentage of increase	1974-1980	82%
	1980-1985	272%
Total increase in average monthly cost utilities		₱ 78,144.28
Total average percentage of increase		144%

6. Others: janitorial, contractual (wages & supplies) security – heavy pilferage & loses
7. Taxes

2. Administrative problems

Poor management
- poor managerial skills
- lack of good managers
- Filipino values – we have to contend with a lot of these factors

a. gaya-gaya – tendency to overlapping service
b. pasikat – what you have – I should have better
c. no project/feasibility studies – "bahala na" "kahit paps"
d. sa akin muna at sa akin munang pamilya bago sa iba
e. pa easy-easy
    1. low productivity
    2. mañana system
    3. at saka na
f. utang na loob
    1. pakikisama – cumpadre system (unqualified workers)
g. walang malasakit lalo na at hindi sa akin (no concern-wasteful)
h. ningas-kugon (not consistent/nor persistent)

3. Manpower/Labor problems

By the nature of its work, hospitals are dutybound to operate 24 hours a day, 365 a year necessitating an adequate complement of employees to enable the institution to render its services at any given time. Health care workers are supposed to work only:

40 hrs/week or about 21.67/day/month
the 6th day or 7th day is 1.3 x
the legal holidays 2.5 x

on top of these we have the:

overtime pay
night differential pay
special area pay
hazard pay
cost of living allowance
13th month pay
uniform

Table III. Salaries and Wages

Minimum wage:		
	1974	₱ 8.00/day
	1980	14.00/day
	1985	37.00/day
Increase in minimum wages from	1974-1980	6.00/day
	1980-1985	23.00/day
Percentage of increase	1974-1980	75%
	1980-1985	164%
Emergency Living Allowance	1974	₱ 50.00/month
	1980	380.00/month
	1985	510.00/month
Total increase in ELA	1974-1980	330.00/month
	1980-1985	510.00/month
Percentage	1974-1980	66%
	1980-1985	134%
Total percentage of increase in minimum wage and minimum (ELA/month)	1974-1980	176%
	1980-1985	102%

a. increase in salaries and wages
b. improper hiring and orientation
c. lack of qualified personnel
d. improper tools, machineries
e. job opportunities abroad (rapid turnover)
f. continuing education and training (costly)

The 3:1 personnel to patient ratio must be maintained so the staffing pattern becomes quite expensive. Because of straight duty of the nursing personnel they work effectively only for about 4 to 5 to 5&1/2 hours utmost/day.

Private hospitals who make money are always looked upon as mercenary – "mukhang pera", "highway robbers" and if you don't manage well and lose then that is bad management.

And last but not least let us have a change of heart . . .

As I have implied earlier and now state categorically, the hospital must be run like a true business enterprise in this present day materialistic environment. It can no longer be a purely humanitarian or heroic public service utility. Silently waiting in the wings to render service only when needed or resisting commercialization thru publicity. It must now make its presence felt thru proper public relations, exposing its good services to the public, and competing in the open market to be able to sell its good services to the public. This principle is necessary if it is to survive and remain tenable during this crisis.

Not only should the hospital be run like any other business undertaking, but it must be able to devise, implement and maintain sound economic policies.

In closing, I would like to remind you that we are supposed to be responsible and concerned entities in our society. We must be fully aware and realize the seemingly insurmountable problems of our times. We cannot depend on ourselves alone but must ask every ministry concerning citizens to hold hands, come work with me. We, therefore, have to be resilient and possess a stronger zeal as well as determination to bring our hospitals over the hump. Let us continue to work harder with concern, dynamism, intensity, dedication and enthusiasm as we have used to before. To survive this crisis one should try:

- restudy our own needs and objectives of care
- prevent losses – in the hospital
- recover costs
- try hard to get even a small profit
- improve the quality of care inspite of turbulent times and economic crisis – make do with that little we have.

Pray harder for divine guidance and patience as we finally weather the storm towards a better tomorrow.

Open Forum

In his reaction, Mario Taguiwalo, special assistant to Health Minister Alfredo Bengzon, noted that supply industries to hospitals like medical education, drug firms, etc. are "immensely profitable" while the hospital as an industry is not.

He said that the government should work towards providing public health services to those who cannot afford. He noted that the past regime of deposed President Marcos has "confused the mission" of the government hospital system by catering more to the needs of those who have the ability to pay. This was best exemplified by the four specialty centers (Heart Center, Lung Center, Kidney Center Foundation and Lungsod ng Kabataan or Children's City), which were given huge financial allocations.

He said that the competition between government and private health facilities should stop, with the government concentrating more on providing health services to the "least capable", which is also a form of "wealth redistribution."

Another reactor, Dr. Jose Tiongco of the Davao Medical Center and the Medical Missions Hospital, stressed that health is "a basic human right and as such, is a basic obligation of the State to its Citizenry."

Tiongco scored the lopsided distribution of hospitals where about 15 percent of the population gets to enjoy 60 percent of the total health care facilities while the poor majority have to content themselves with the remaining 40 percent. He urged the hospitals to "give back the concept of illness" to the community and that instead of viewing Filipino values as something negative, these can be harnessed just like "people power."

On the question whether the country needs more hospitals, the consensus reached by the audience was that a survey should be made to determine the type of health services that are needed per locality. The need to improve the quality of health services in the provincial level was also aired particularly in providing adequate sanitation facilities to combat communicable diseases.

Taguiwalo urged the health professionals to desist from using the bed-population ratio as this "does not mean anything." He lambasted the old legislature for coming up with a "stupid" provision that every province should have a hospital with a 100-bed capacity without considering the demographics and health needs of the area.

On the issue of the four specialty centers and what should be done with them, Dr. Priscila Tablan, executive director of the Lung Center of the Philippines (LCP) dared the audience to visit the LCP first before they think of "doing away with it." Tablan said that she tried to make the center available to the public and no distinctions have been made between patients who can and cannot afford to pay. The LCP she said, was able to become semiviable despite a measly budget of P10 million for 1985 and this year. The center was also able to sustain 60 percent of charity patients because "we know that our target is the poor people."

Taguiwalo said that the four specialty centers will make residency training programs available.

The role of hospitals should be expanded beyond the curative, said Tiongco, and patients and their relatives must be educated on the basics of good health. Alliance of Health Workers Chairperson and UP Prof. Minda Luz Quesada called for a systematized and institutionalized patient health educational program in all hospitals as a preventive means to combat ill health.

On the issue of private hospitals receiving subsidies from the government, Taguiwalo said that this will further constrict the already meager health financial resources. A plan, instead, can be worked out whereby hospitals provide emergency services and claims to such provisions be made against a subsidy to be provided by the government, said Taguiwalo.

While agreeing to Tiongco's assertion that health is a basic human right, Taguiwalo said that this right is "modified by the extent of the capability of the economy." He said that the government will provide health services only when "it will enable a person to be more productive."

CHAPTER 6

Ensuring Filipino Workers' Health and Safety

Maris Presto

An Overview of the Labor Situation

In the midst of the crippling health situation in the Philippines, the workers have always been part and parcel of the struggle to survive. They are the major bulk of sweatshop industries, huge plantations and services comprising the 21 million labor force in the last year's total population (Figure 1).

Figure 1

PHILIPPINE LABOR FORCE, 1985

TOTAL POPULATION (1985)	55 MILLION
POPULATION 15 YRS. & ABOVE	32.4 MILLION
MALE	15.9 MILLION
FEMALE	16.5 MILLION
LABOR FORCE	20.6 MILLION
AGRICULTURE	9,733,000
INDUSTRIAL	2,899,000
SERVICES	7,041,000

SOURCE: NCSO, SPECIAL ISSUE
APRIL 23, 1985

Considered as vital to a nation's development, workers have the ultimate right to safe and humane working conditions. This encompasses their general socio-economic and political situation which has a major bearing on their health and safety.

Only 85.4% men and women in the labor force are employed (Figure 2). But this does not mean that those who are employed are all that fortunate. The existing ₱57 minimum wage since November, 1984 cannot provide a decent standard of living. In the second half of 1985, it was estimated that a worker had to earn ₱112 a day to meet the basic needs of a family with 6 members. Worse, only 10% of companies in 1985 implement the legally mandated minimum wage.

Figure 2

1985 LABOR FORCE	20.6 MILLION
EMPLOYED	17.6 MILLION
UNEMPLOYED	3.0 MILLION (26% OF LABOR FORCE)
LAID OFF WORKERS (JAN.-NOV. 1985)	65,000

SOURCE: DATOS, VOL V., NO.4 OCT.-DEC 1985

What then is the purchasing power of this measly salary? In 1985, the Food and Nutrition Research Institute (FNRI) stated that the cost of daily essential nutrients needed by an adult amounts to ₱64.70 (Figure 3). This implies that the worker is deprived not only of freedom from hunger, but also susceptible to communicable diseases due to depleted body resistance.

Figure 3

MALUSOG ANG PAMILYA KUNG MAAYOS ANG KITA

Ayon sa surbey ng FNRI, ang pagkain sa araw-araw ng karaniwang pamilya ay salat sa mahahalagang sustansiya tulad ng protina, vitamin A, thiamine, riboflavin, calcium, ascorbic acid, at iron.

1 malaking lata ng gatas ebaporada ₱10.20

3 itlog (medium) ₱4.20

2 kilong cereal (bigas) ₱14.50

1/2 kilong maberde at madilaw na gulay (kangkong)

1/2 kilong iba pang prutas at gulay ₱2.15

1 kilong isda (galunggong) o karne ₱21.90

1/2 kilong rootcrops (gabi) ₱3.90

100 gramong dried beans at nuts ₱2.20

150 gramong asukal (repinado) ₱1.15

1/2 kilong pagkaing mayaman sa vitamin C (kamatis) ₱2.30

*FOOD AND NUTRITION RESEARCH INSTITUTE

SOURCE: IBON EKONOKOMIKS
PIL. ED. VOL. II, 1985
NO. 8-19

Unhealthy living conditions in the urban poor communities where workers usually settle is another predisposing factor for acquiring disease. Eighty six percent of families in urban areas rent a "one room affair" for ₱150 to ₱350 a month. Lack of proper waste disposal, inaccessibility to safe drinking water, stagnant canals and lack of toilet facilities enhance the spread of diseases.

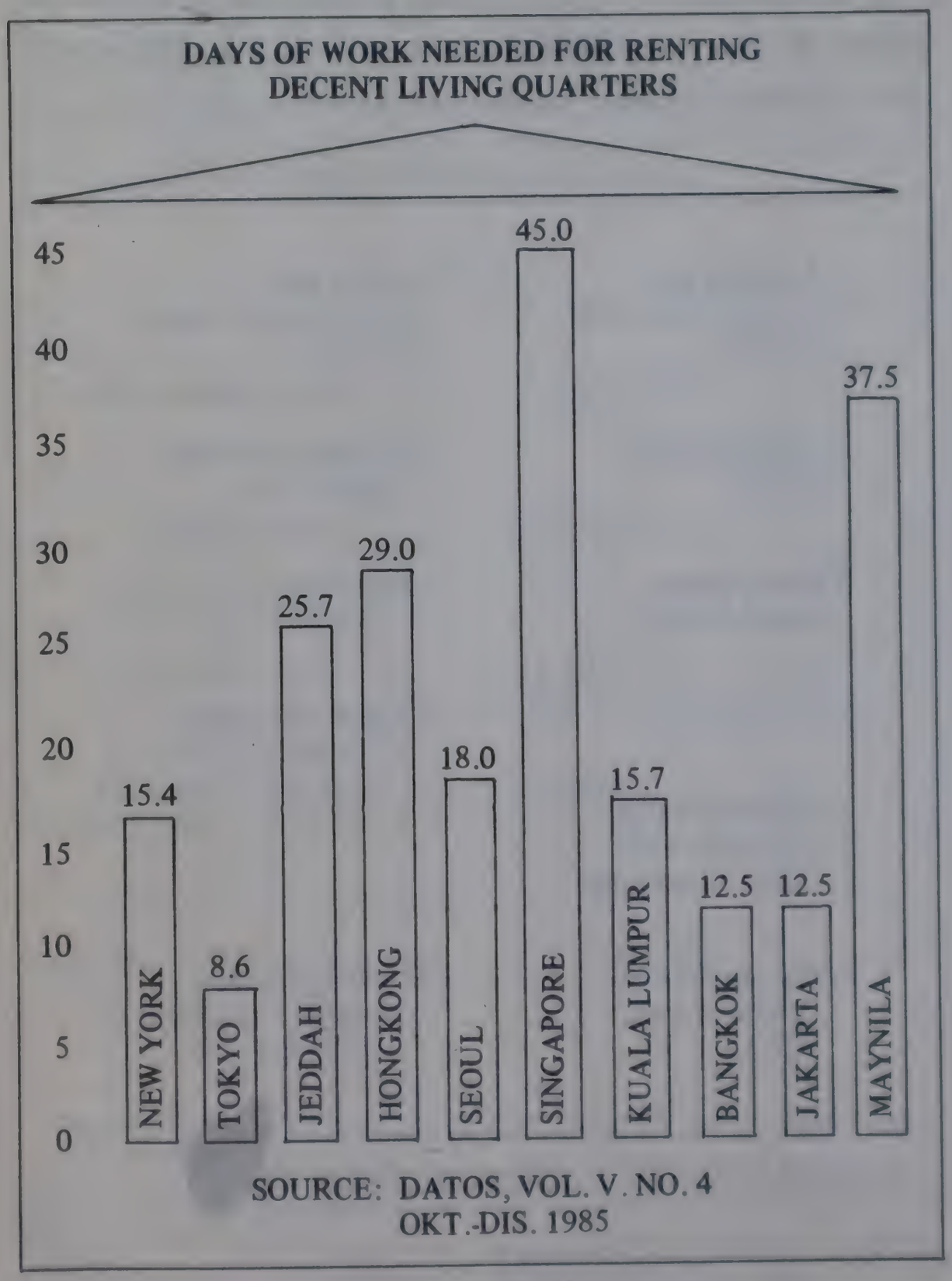
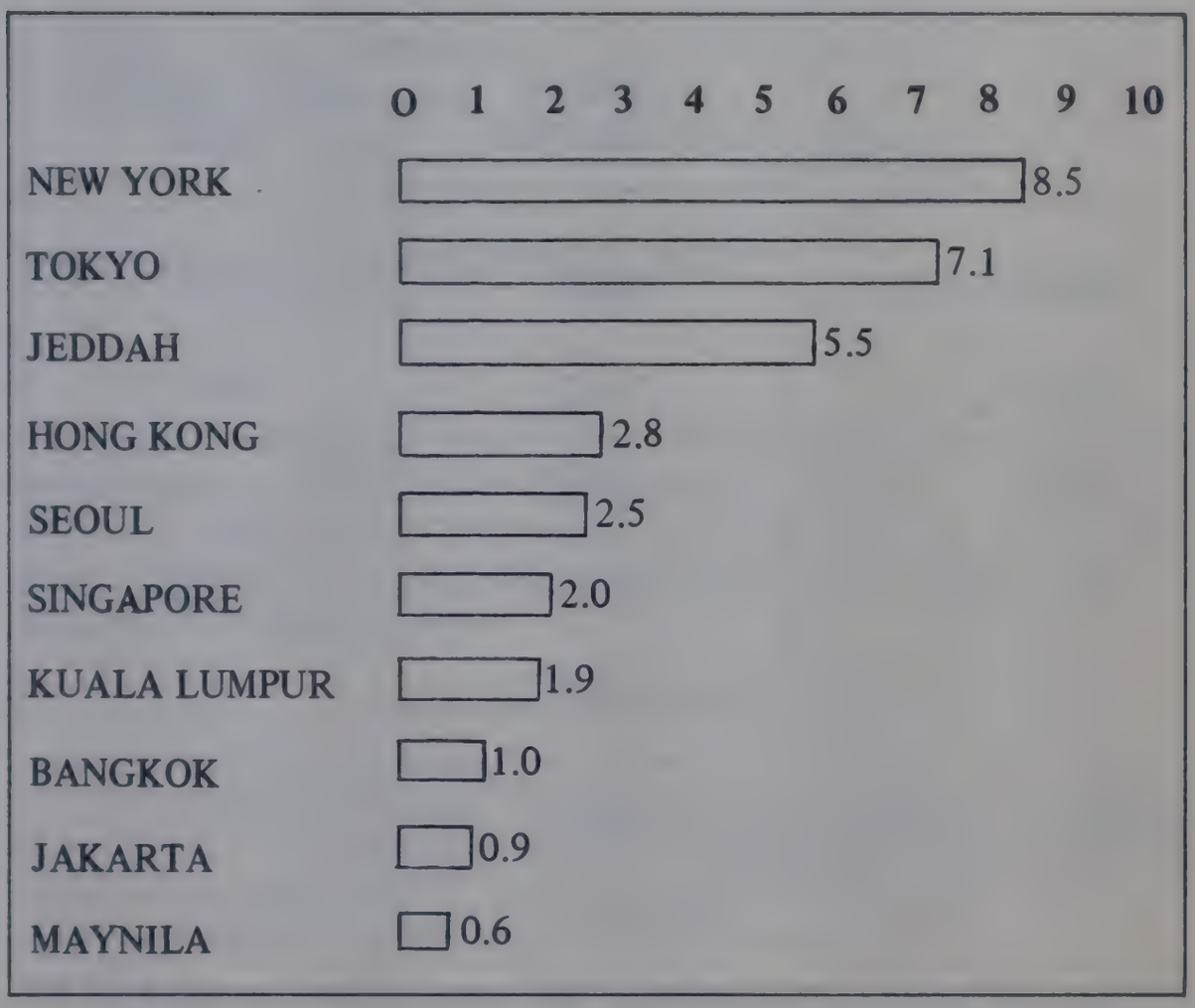


Figure 4

In a recent study conducted by the Ecumenical Institute for Labor Education and Research (EILER), a Filipino worker has to work for one month, 11 days and 4 hours so as to afford the monthly rent for fairly decent living quarters (Figure 4). This simply means that the present number of working days is deficient of 11.5 days for a worker to afford a better shelter alone. Moreover, urban poor workers are often subjected to forced demolitions.

Figure 5

COMPARISONS OF SALARIES IN 10 CITIES
SALARIES (US$/Hour)



SOURCE: DATOS, VOL. V., NO. 4
OKT.-DIS. 1985

A comparative study done regarding the workers' wages in 10 cities revealed that the Philippines is still the place to go for lowest wages and highest profit (Figure 5). Based on the data, an American company can save US$7.90 per hour per worker if he will transfer his factory here from New York.

Using Filipino cheap labor as a come-on, the corrupt and anti-nationalist regime of Mr. Marcos opened the doors of the Philippines wide open for foreign investment. The rationale was that foreign investment would help to revive our sinking economy. In reality, these transnational and multinational corporations and their Filipino partners have greatly profited at the expense of the workers and the country as a whole.

Figure 6

TOP INVESTORS IN THE PHILIPPINES
JANUARY-SEPTEMBER 1984

	AMOUNT (IN MILLION)	PERCENTAGE SHARE
AMERICANS	868.0	38.0
DUTCH	296.7	13.2
THAIS	163.0	7.3
JAPANESE	157.0	7.0
MALAYSIANS	145.6	6.5

SOURCE: METRO MANILA TIMES
DEC. 12, 1984

To cite proof, let us examine the gross national product of the Philippines (Figure 7). The GNP which represents the total value of the manufactured products and services in a definite period, should be fairly distributed among its people. In 1984, the GNP of the Philippines amounted to ₱535,885,000. From this, a family of six members should receive ₱167.42 a day. This is higher than the estimated ₱105.60 daily living expenditures. However, close to 84% of families in Metro Manila (1984) earn lower than ₱167.42 which is supposedly their share from their contribution to the national income. Who therefore benefitted from the so-called industrialization?

Figure 7

DISTRIBUTION OF INCOME

PER CAPITA GNP	=	$\frac{\text{GNP (CURRENT) 1984}}{\text{POPULATION 1984}}$
	=	$\frac{\text{₱535.89 BILLION}}{\text{53.35 MILLION}}$
	=	₱10,045/YEAR
MONTHLY PER CAPITA GNP	=	₱837.08
DAILY PER CAPITA GNP	=	₱ 27.90
₱27.90 X 6 MEMBERS OF A FAMILY	=	₱167.42/FAMILY

SOURCE: IBON EKONOKOMIKS, BLG. 9
PEB. 1985

Finally, because of the economic crisis and unemployment problem, more than two million workers were forced to migrate to at least 123 countries. They suffered not only the psychological pain of separation from loved ones but were also confronted with poor and oftentimes, inhuman working conditions.

Occupational Health and Safety

While the previous regime, in collaboration with the business sector, has exerted a lot of effort to improve production and push an export-oriented economic strategy, very minimal concern has been given to the health conditions of the producers, the workers themselves.

Despite the presence of Occupational Health & Safety Standards, many employers simply do not comply with these. In 1981 alone, 81% of 367 inspected establishments were found violating general labor standards by the Labor Ministry, and 14% of 3,659 firms were violating technical safety standards.

The most common rules under the Philippine Occupational Health & Safety Standards which are grossly violated or disregarded by most employers are the following (Figure 8):

Figure 8

LIST OF OCCUPATIONAL SAFETY AND HEALTH STANDARDS WHICH ARE GROSSLY VIOLATED BY EMPLOYERS

RULES	
1005.1	DUTIES OF EMPLOYERS
1041	GENERAL REQUIREMENT FOR SAFETY COMMITTEE
1042	COMPOSITION OF SAFETY COMMITTEE
1043	DUTIES OF SAFETY COMMITTEE
1062	SPACE REQUIREMENT
1070	OCCUPATIONAL HEALTH AND ENVIRONMENTAL CONTROL
1076	GENERAL VENTILATION
1080	PERSONAL PROTECTIVE EQUIPMENT/DEVICES
1093.04	MARKING OF CONTAINERS
1963	EMERGENCY MEDICAL AND DENTAL SERVICES
1965	DUTIES OF EMPLOYER/PHYSICIAN/NURSES
1967.03	PERIODIC ANNUAL MEDICAL EXAMINATIONS

Rule 1005.1: Duties of Employers

"Each employer covered by the provisions of this Standards shall: a) furnish his workers a place of employment free from hazardous conditions that are causing or are likely to cause death, illness or physical harm to his workers; b) give complete job safety instructions to all his workers, especially to those who are entering the job for the first time, including those relating to the familiarization with their work environment, hazards to which the workers are exposed to and steps taken in case of emergency; c) comply with the requirements of this Standards; and d) use only approved devices and equipment in his workplace."

Majority of employers in hazardous industries do not protect workers from toxic substances such as chemicals, cotton fibers and noise. In fact, they do not provide them with adequate safety devices. Moreover, no safety instructions are given to workers regarding the health hazards involved in their work and steps to be taken in case of emergency. Almost all the factories we have studied exhibited this negligence.

Rule 1041: General Requirement for Safety Committee

"In every place of employment, a safety committee shall be organized within 60 days after this Standards takes effect and for new establishments within one month from the date the business starts operating. In both cases, the Safety Committee shall re-organize every January of the following year."

Rule 1042: Types and Composition of Safety Committees

"In every workplace having a total of over 400 workers the following safety committee shall be organized:"

TYPE A –

Chairman: The manager or his authorized representative who must be a top operating official

Members:
- Two department heads
- Two workers (must be union members, if organized)
- The company physician

Secretary: The safety man

TYPE B – in every workplace having a total of over 200 to 400 workers, the following safety committee shall be organized:

Chairman: The manager or his authorized representative who must be a top operating official

Members:
- one supervisor
- one worker (must be union member, if organized)
- the company physician or the company nurse

Secretary: The safety man

TYPE C – in every workplace with one hundred (100) to 200 workers, the following shall be organized:

Chairman: Manager or his authorized representative

Members:
- one foreman
- one worker (must be union member, if organized)
- the first aider

Secretary: Appointed by the chairman

TYPE D – in every workplace with less than 100 workers, the following shall be organized:

Chairman: Manager
Members: – one foreman
– one worker (must be union member, if organized)
Secretary: Appointed by the chairman

TYPE E – Joint Committee

"When two or more establishments are housed under one building, the safety committee organized in each workplace shall organize themselves into a joint coordinating committee to plan and implement programs and activities concerning all the establishments."

> Very few companies organize safety committees. If ever there is one in the company, the bulk of its composition comes from the management side. Usually, only one or two workers are involved; giving unequal chance for the workers to participate. As a result, the real demands of workers are overlooked and are not immediately acted upon.

Rule 1043: Duties of Safety Committee

"The Safety Committee is the planning and policy-making group in all matters pertaining to safety. The principal duties of the Committee are: (1) Plans and develops accident prevention programs for the establishments. (2) Directs the accident prevention efforts of the establishments in accordance with the safety programs, safety performance and government regulations in order to prevent accidents from occuring in the workplace. (3) Conducts safety meetings at least once a week. (4) Reviews reports of inspections, accident investigations and implementation of program. (5) Submits reports to the manager on its meetings and activities. (6) Provides necessary assistance to government inspecting authorities in the proper conduct of their activities such as the enforcement of the provisions of this Standards. (7) Initiates and supervises safety training for employees."

> Established safety committees emphasize accidents more rather than the occupational diseases which might arise from the potential hazards which the workers are exposed to.

Rule 1062: Space Requirement

"(1) Workrooms shall be at least 3 meters (9 ft. 10 in.) in height from the floor to the ceiling. Where the rooms are air-conditioned and the process allows free movement, existing heights of not less than 2.2 meters (7 ft.) may be allowed. (2) The maximum number of persons employed in a workroom area shall not exceed one person per 11.5 cubic meters (400 cu. ft.). (3) Adequate spaces shall be provided between machinery or equipment to allow normal operation, maintenance or repair and the free flow of materials under process or in finished form. Passageways between machinery or equipment shall not be less than 60 cm. (24 in.)"

Many workplaces are crowded that machines and workers are cramped in a small space, a virtual health hazard. This is the case in the semiconductors industry whereby workers in one station can easily inhale the chemical fumes coming from the other station, especially if there is no exhaust system.

Rule 1070: Occupational Health and Environmental Control

"This rule establishes threshold limit values for toxic substances which may be present in the atmosphere of the work environment. Threshold limit values refer to airborne concentration of substances and represent conditions under which it is believed that nearly all workers may be repeatedly exposed daily without adverse effect."

For many employers, it is difficult to determine whether they are complying with the threshold limit values because no surveillance is being conducted in the workplace. But in those companies where studies have been conducted, it was noted that the concentration of noise, chemicals and cotton fibers are often beyond these limitations.

Rule 1076: General Ventilation

"Atmospheric Conditions – Suitable atmospheric conditions shall be maintained in workrooms by natural or artificial means to avoid insufficient air supply, stagnant or vitiated air, harmful drafts, excessive heat or cold, sudden variations in temperature, and where there is practicable, excessive humidity or dryness and objectionable odors."

Majority of workplaces are either extremely hot or extremely cold, depending on the nature and requirement of the product being processed or assembled.

Workers are usually the ones adapting to the workplace, instead of the workplace being suited to the workers.

In the studies we have conducted, textile workers are constantly exposed to cotton dust due to inadequate exhaust ventilations; whereas in the tin dipping and tin plating sections of the semiconductors industry, noxious gases are noticeable despite exhaust fans.

Rule 1080: Personal Protective Equipment and Devices

"Every employer shall furnish his workers with protective equipment for the eyes, face, hand and feet, protective shields and barriers whenever necessary by reason of the hazardous nature of the process or environment, chemical or radiological or other mechanical irritants or hazards capable of causing injury or impairment in the function of any part of the body through absorption, inhalation or physical contact.

"All personal protective equipment shall be of the approved design and construction appropriate for the exposure and the work to be performed. The employer shall be responsible for the adequacy and proper maintenance of personal protective equipment used in his workplace. No person shall be subjected or exposed to a hazardous environmental condition without protection."

Provision of adequate personal protective equipment or devices to workers is often neglected except if it, will endanger the quality of the product being assembled. For example, the use of masks in textile factories can be taken for granted by the management but not in the semiconductors industry where the minute integrated circuits or ICs are very sensitive that even the slightest bit of dust is not allowed to contaminate.

Rule 1093.04: Marking of Containers

"All containers with hazardous substances should be properly labeled. No employer within the scope of this Rule shall accept any container of hazardous substances for use, handling or storage unless such containers are labeled. Labels shall contain the following information: symbol of hazards (explosive, flammable, oxidizing, toxic, corrosive or radioactive), trade name and chemical name, a description of the principal risk, necessary precautions, and first aid in case of emergency."

Workers are ignorant of the names of the chemicals they are handling because of lack of labels or if there are labels, these are coded. When we visited a banana and pineapple plantation in Mindanao, we observed that most of the pesticides handled by workers have no labels. Symbols of hazards were also lacking. Worse, these pesticide containers find their way to the consumers as storage of food, water or other drinks.

Rule 1963: Emergency Medical and Dental Services

"Every employer shall keep in his workplace the minimum medicines and/or facilities required, and shall provide free medical and dental services by hiring the following health personnel:

10 – 50 workers:	one graduate first aider
50 – 200 workers:	a full time registered nurse or a full time first aider (if non-hazardous)
200 – 300 workers:	a full time registered nurse, a part time physician and a part time dentist, and an emergency clinic (doctors and dentist shall stay not less than two hours a day
more than 300 workers:	a full time nurse per shift, full time dentist and dental clinic, an infirmary or emergency hospital with one bed capacity per 100 workers. The physician and dentist shall stay in the premises of the workplace for at least 8 hours a day."

Company clinics are often unmanned or have inadequate medical supplies. Physicians usually come once or thrice a week, and stay for one to four hours, even if the number of employees is more than 300 and the industry is hazardous.

In fact, many nurses and physicians within the company are not aware of the potential hazards involved in the production lines. Thus, occupational and work-related diseases are often misdiagnosed.

Rule 1965: Duties of Employer/Physicians/Nurses

"Employer shall: establish occupational health services, adopt a comprehensive occupational health program for his employees, enter into contract with hospitals or dental clinics, maintain a health record of programs and activities and submit an annual report to the Regional Labor Office.

Physicians (part time or full time) shall:
organize and administer a health service program intergrating therein an occupational safety program, conducts studies on occupational health, prevent disease or injury in the workplace by establishing proper *medical supervision over substances used, processes and work environment,* provide medical services, maintain medical records, proper health education report and advise management regarding health matters.

Nurses shall: coordinate and actively participate with the physician in carrying out the above mentioned duties of a physician; in case a doctor is not available, she will have to organize and administer a health service program including occupational health and safety."

It is the moral responsibility of both the employers and the medical personnel to adopt a comprehensive occupational health program for the protection of the workers. But more often than not, services are limited to treatment of illness and injuries. In fact, many employers require their nurses to inspect the canteen but do not allow them to go inside the production lines regularly, where potential risks can be found.

Likewise, company nurses in many industrial settings assume other tasks like telephone operator, typist, or even actual work in the production department, without additional benefits. Thus the quality of care being rendered suffers.

Trainings, if there are any, focus on accident prevention alone, on improving the quality of the product being produced, or even family planning methods.

None or few companies in cooperation with their medical staff have taught their workers first aid, the hazards involved in their work, and the skill of recognizing occupational hazards. Learning to use a simple checklist for example, will help workers detect potential hazards.

Rule 1967.03: Periodic Annual Medical Examinations

"Periodic annual medical examinations shall be conducted in order to follow-up previous findings, to allow early detection of occupational and non-occupational diseases, and determine the effect of exposure of employees to health hazards."

Majority of companies include only physical, laboratory (routine examinations i.e. urinalysis & complete blood count) and chest x-ray examinations. Special examinations deemed necessary for the detection of occupational diseases and determination of the effect of health hazards like blood metal assay, lung function tests, audiometric examination and eye check-up are not being done in almost all companies.

The information above are based on the findings of occupational health researches done by the Factory-Based Primary Health Care (FBPHC) program in six lines of industry for the past three years. We have attempted to review studies by other groups but it seems that either there are no comprehensive studies on occupational health conditions of workers that have been done, or these are just not made available to us.

For instance, when I approached the industrial hygienist of UP – Institute of Public Health, she said they had already conducted a number of surveys on occupational health but couldn't give any data (written report) about their findings. She then referred the staff to the Institute of Labor, Manpower Studies (ILMAS) of MOLE where she knew most the findings of their studies were submitted. Unfortunately, staffers of ILMAS were not aware of those studies when FBPHC staff asked them, while the Bureau of Working Conditions of MOLE had only accident reports.

Actual negligence of employers in providing a safe and healthy working environment will be discussed in the following lines of industries noted for being labor-intensive and hazardous. Other lines of

industries which have also been proven hazardous in other studies are the plastics industry, food and drug industry, pesticides manufacturing and mining industry.

Textile Industry:

The textile industry used to be among the biggest employers of which the top ten textile factories hire an average of about 1,000 workers. By 1984, the Textile Millers Association of the Philippines (TMAP) estimated the workforce at 60,000. The number decreased to about 46,000 this year.

Textile workers are constantly exposed to cotton dust, heat and noise. Despite the wearing of the masks, workers frequently inhale the thick fiber dusts known to them as "flywastes", particularly in the spinning and weaving areas. Inadequate exhaust ventilation, antiquated machines and poor house-keeping result in a dusty atmosphere. In one factory, many workers complain of chest tightness and chronic cough after an average of 14-20 years of exposure to cotton dust. Worse, some of them might already be suffering from byssinosis, a chronic lung disease due to accumulation of cotton fibers.

There is also relatively high temperature in the workplace. Heat is generated from spinning and weaving machines or from steam released during dyeing and finishing processes. In the latter processes, temperature reaches up to 100 degrees centigrade. Among 375 interviewed workers, an average of 73% complained of extreme heat in the workplaces. Symptoms of headache, easy fatigability, dizziness, feeling feverish and nosebleeding are usually experienced by the workers.

The mechanized nature of the textile industry poses the serious problem of occupational deafness. The noise levels in many workplaces in the three factories surveyed by the FBPHC staff were above the set limit of 90 dB. Most workers resort to shouting in order to be heard at work and often use sign language to communicate with co-workers inside the production line.

Furthermore, workers in the Preparatory and Finishing departments handle at least 50 different types of chemicals, excluding the numerous dyestuff of which only brand names are known to the workers.

Frequent accidents like puncture wounds, lacerations, finger cuts, avulsion or amputation and chemical spills are often blamed on workers' carelessness.

In two factories, the workers were not provided with a replacement of their thin masks and gloves unless they are already torn. In another factory setting, the male workers in the finishing department requested for "supporters" due to fear of having "luslos ' (hernia) as a result of lifting and transporting heavy rolls of textile from one place to the other. Unfortunately, the management told the workers that they cannot provide supporters since no such cases have been reported yet.

With regard to health personnel, a nurse in one factory works as a "rewinder" in the production if she has no patients. One worker commented that this is part of the employer's "cost reduction program" . . . maximization of time even if it is outside an employee's job description.

In another factory with almost 2000 workers, 3 full time nurses, 2 part time doctors and one full time dentist are employed. In our survey, workers complained of discrimination in providing health services. Also, workers have to pay for the needle and anesthesia used in tooth extractions.

In their annual check-up, the only services offered were chest x-ray, eye check-up and physical examinations. Workers who were found suffering from tuberculosis based on the result of their chest x-ray are forced to go on prolonged leave. In one factory, once the number of sick leaves have reached more than a year due to such forced leave, the management will offer a voluntary resignation paper to the worker. This has been arrogantly carried out by the employer knowing that Article 285 of the Labor Code justifies disease as a ground for terminating workers. This is also the trend in other factory settings.

Although a union-management health & safety committee exists, only one worker from the union was authorized to join the committee. Realizing the negative impact of such kind of representation, the union insisted that there should be equal participation from the rank-and-file workers. In this way, they can also have equal bargaining power in terms of planning actions to improve their working conditions.

Semiconductors Industry:

The semiconductors industry has always been projected by employers as a clean industry that would pose few health and safety problems to its workers. This is so because the chips, which is the main product of this industry, should not be contaminated by any slightest bit of dust. Workplaces are well ventilated or airconditioned, and workers wear white gowns, head caps, masks and finger cots.

In 1981, there were about 32,000 Filipino workers in the semiconductors assembly work, eighty five percent of whom are women workers aged 16 to 25 years. Capitalists prefer women workers because of their manual dexterity, patience for repetitious jobs, and docility. They are the ones exposed to the health hazards found in the workplace.

According to the National Institute on Occupational Safety and Health (NIOSH), of the U.S. Public Health Service, semiconductors is the third most hazardous industry in terms of the degree of workers' exposure to toxic chemicals. Among these chemicals are the epoxy resins, solvents, fluxes and other acids necessary in making integrated circuits or chips. Most workers handling these chemicals in the Tin Dip and Molding sections complain of contact dermatitis, eye irritation, dizziness, upper respiratory tract problems and reproductive problems like frequent abortion.

Chemicals like lead, trichloroethylene and freon also affect internal organs like the liver and kidney. Latent illnesses like cancer are often felt after 5-10 years of exposure to chemicals, by which time, the worker may have already been retrenched from the company. Pregnant workers endanger the health of their baby inside the womb in the form of low birth weight, premature birth or birth defects.

The ventilation and air-filtering systems used to safeguard the product from dust dissipate small gas leaks and the airborne products of chemical spills. Workers in airconditioned room may not be aware that they are slowly being exposed to chemicals. The truth is that airconditioning systems do not alter chemicals but rather dilute and recirculate them; smocks, masks and head gear do not protect workers from toxic exposure. They were not even given safety instructions prior to actual work.

Are we still going to wait for another Elfreda Castellano who died of malignant lymphoma after two years exposure to chemicals in tin-dip, before we push on our workers' right to know the names and hazards of the chemicals they are handling?

Good vision is another pre-requisite to this industry. The worker focuses her eyes into the microscope lens for less than eight hours each working day. She is even compelled to hasten the process of bonding and peeping into the microscopes to comply with her quota. Then after two to three years, her complacency has resulted in blurring vision and inability to perform her routine job.

It was also observed that majority of the companies do not include thorough examination of workers' vision in the annual examination. Necessary eyeglasses are either shouldered by the worker alone or paid by the management first, and later deducted from their succeeding salaries. In one factory, the worker and the employer equally share the cost of eyeglasses. But failure of vision may also mean termination of the worker.

Nowadays, many companies are using the television-like visual display units (VDU) instead of microscopes. But due to the low level of radiofrequency radiation being emitted by these VDUs, workers are more likely prone to cataract, cancer and reproductive hazards.

Beset with these major health hazards, the company clinic, which should be a great help to the workers, cannot be relied upon. The company physicians are mostly part time and come once or thrice a week. There is also an obvious discrimination of services. Managers and supervisors are given more medicines and are well accommodated, a far cry from treatment the workers get. If workers get sick, they are required to go to the clinic and notify the medical staff on the same day. If not, their sick leave will not be approved by the nurse or the physician.

Steel Pipe Industry:

Similar to the first two lines of industry, workers in the steel pipe industry are also exposed to hazardous chemicals like asbestos. The minute fiber of asbestos can easily get into the body through inhalation and ingestion resulting in a disease known as asbestosis.

Asbestosis is a progressive scarring of the lungs manifested by increased breathlessness upon exertion and transient sharp chest pain. This usually occurs after 10 years of exposure to asbestos dusts. Yet, workers are inadequately provided with safety gear or clothing and are not oriented on its possible health risks. The reinforcing effect of smoking to asbestosis is not even discussed with workers, who are mainly males.

Aside from this, excessive noise, extreme heat and accidents like lacerated wounds are also noted in this kind of work.

In case of illness or injury, part time physicians and inadequate supply of medicines were again the complaints of most workers in two steel factories. Usually, only prescriptions are handed down to them.

Footwear Industry:

The footwear industry is a group of business firms engaged in the manufacture of shoes, sandals, slippers, clogs and similar products. From the previous "Ang Tibay Elpo, Marcelo, and Esco" brands of footwear down to the latest "Grosby, Adidas, Puma and Otto", the footwear industry now belongs to the export sector.

The workers though are still not exempted from the use of risky chemicals. They, too, experience dizziness, chest tightness, dermatitis and eye irritation from chemicals like Mercapto, sulfur, vinyl chloride, vulcadent/E, and rugby. Many chemical containers are coded so it is difficult for them to trace the exact cause of the symptoms they are suffering from. What workers know is that these chemicals are either accelerators, activators or retarders.

. The workplaces are not also free from extreme heat and smoke dust from rubber. The rattling noise of sewing machines is deafening to the ears. But workers in one big firm we surveyed were not provided with ear plugs or ear muffs.

Finger cuts and lacerations due to failure of machine brakes are common in the cutting department. When asked if they have undergone any safety instructions, the workers claimed they were simply oriented on the company rules and how to operate machines, nothing else.

The workers here are confronted with a number of unjust working conditions. To spur production, workers are forced to comply with quotas. Although a corresponding benefit is offered to anyone who can comply with it, workers feel they are being cheated by the management. While suffering from backache, fatigue and tension, quotas are constantly increased once the majority of the workforce can comply with them. So it is almost impossible for them to get the incentive pay.

In the largest rubber footwear company in the Philippines, workers have only 20 minutes meal break and 15 minutes for snacks. Because they have to rush back to their work after eating, many complained of abdominal indigestion. According to them also, many refrain from going to the canteen for a break or to the toilet for personal necessities so as to accomplish their required quota faster. Consequently, workers suffer from ulcer and urinary tract infections. Others accidentally stitch on their hands when they hurry to reach their quotas.

In another factory, discipline is sometimes imposed unjustly. Coming in one minute late brings a written warning. One day sick leave without notice is penalized with seven days forced leave.

In the same top rubber footwear factory, there was one incident where a worker who was eight months pregnant complained of abdominal pain to the company physician. The doctor assured her that the pains were normal for a pregnant woman. On the third time the worker complained of pain, the physician still did not allow her to leave the company. After a while, the worker started bleeding and delivered her child inside the factory. Obviously, the management protected the physician from the workers' allegations, but the workers' anger pressured the physician to resign from her work.

Plantation Industry:

Extensive use of pesticides and other agrochemicals was highly noted in plantation settings. Constant exposure to these pesticides pose grave health hazards to workers. The lack of proper health orientation among workers further aggravates their deplorable conditions.

The study conducted on pesticide poisoning in Bulacan by Dr. F. Jose of UP Institute of Public Health revealed that farmers and sprayers of pesticides were not given proper education on the correct use of pesticides and hazards involved in spraying these. They wore no protective devices, too. Sad to say, personnel in the hospitals studied do not know the proper treatment for pesticides poisoning.

In 1985, the FBPHC of the Council for Primary Health Care conducted a similar study in Mindanao. There were about 21,000 pineapple workers and 30,000 banana workers.

Aside from the very low wages received by workers, they are oftentimes forced to work overtime up to 16 hours a day. Workers claimed they have no choice because the only truck they can ride on refuses to transport them back to the town centers which is several kilometers away.

Both men and women carry heavy loads. Banana harvesters carry up to 60 kilos of bananas; pineapple pickers carry up to 20 pineapples in a canvas sling on one shoulder. Knapsack sprayers of pesticides carry up to 40 kilos on their back.

Although there is a hospital and a clinic near the plantation sites, there is no system of monitoring the health status of workers, especially poisoning due to toxic chemicals. The government's Fertilizers and Pesticides Authority monitors poisoning cases only through the reports of the company hospital, and other government hospitals.

The incidence of diseases and deaths due to chemical poisoning are often misdiagnosed. For instance, three workers were found to have "spots" in their lungs by the company physician. They were told that the condition was due to alcohol abuse. But upon consultation with a non-company physician, they were told that it could be due to chemical exposure. These workers are sprayers, handling various herbicides.

Banned pesticides in other countries still find their way to the Philippines. Yet, workers were never informed about this. They were no protection at all except for improvised masks (T-shirt) and torn boots.

There are really no safe pesticides. Pesticides not only kill pests but other organisms, including human beings.

Response of Various Sectors

The preceding accounts give us an overview of the hazardous and oppressive working conditions in the Philippine setting. The health & safety of workers have been severely neglected and compromised. Workers are being killed or maimed by a number of health hazards which they are not forewarned about or protected from.

Majority of companies have been reluctant to provide protective equipment for their workers. Keeping the workplace free from hazards means added expense and a cut in profit margins. For small companies struggling to survive in the midst of an on-going economic crisis, these types of costs are out of the question. They would much rather replace a worker taken ill than spend to keep him in good health.

The Bureau of Working Conditions of the Ministry of Labor is the one authorized to check if specific laws on occupational health are being implemented. This is being done through periodic inspection of the workplaces. To further draw concrete actions appropriate for specific industrial health problems, they facilitate the tripartite system and conduct researches, too.

Despite these efforts, substandard working conditions remain unchecked in many establishments. The enforcement of labor standard laws have been so weak that majority of employers do not comply with it. In 1984 there were only 50 MOLE personnel assigned to conduct inspections and enforce labor standards in Metro Manila where 30,000 establishments are found (Source: 1984 Tripartite Conference, MOLE).

There was also a common sentiment among many labor groups that the result of the tripartite conference is not representative of the genuine demands of workers in improving the health situation in the factory. As a result, the root causes of these dehumanizing health conditions of workers were discussed quite superficially.

In the UP Institute of Public Health, on-going research on occupational health, requested surveys, and post-graduate courses on Occupational Health and Safety for health professionals are being undertaken. This is a response to the law mandated by the Labor Code that the health professionals must strengthen occupational health services along with the government.

Unfortunately, very few graduates of this course have implemented a comprehensive occupational health program once they are within the premises of industrial settings. In fact, most of them, just like other nurses and doctors who didn't take the study, are not aware of the specific production processes and the health hazards involved within the factory where they work. Thus, the focus of care is limited to curative, rather than preventive.

I know a certain nurse who is very assertive and concerned with the health problems faced by workers. She is also a product of the UP-IPH post graduate course on Occupational Health. During her stay in a multinational company, she submitted a proposal to the management to conduct an occupational health survey with the objective of identifying potential health hazards and gather data which will be beneficial to planning a health program. She also mentioned that lesser health problems among workers would mean increased productivity for the company.

But the manager turned down her proposal and told her that the semiconductors industry is not a hazardous industry. She was even told that she might be creating much financial and moral damage to the company if and when she finds out that the chemicals being used by workers are cancerous and that microscopes affect their vision. In the end, the manager told the nurse that ". . . sitting inside the clinic, waiting for patients, is already a service. It is not anymore the role of the

nurse to go inside the production line and check if the workers are really wearing the protective equipment becasue this is already the task of a supervisor."

At present, the Philippine Council for Health, Research and Development of NSTA is doing a study on the use of vinyl chloride monomer (VCM) in the plastics industry. It is hoped that the findings of this study will later be shared not only among professionals but also with the workers.

Until now, local data remain scarce, handicapping the efforts of workers to improve their working conditions. There are insufficient statistics on work-related diseases except for accidents and injuries.

Other private organizations like the Occupational Health Nurses Association of the Philippines (OHNAP) and Philippine Occupational and Industrial Medical Association (POIMA) undertake staff development sessions to consolidate their efforts in improving the quality of occupational nurses and doctors serving in the factories and other establishments.

On the other hand, the main concept of workers is that occupational health issues revolves around benefits, compensation and medical services from the company clinic including drugs. They know that something is wrong with their working environment when they experience unusual symptoms in their body. But they are not aware that these hazards are preventable. Workers think that illness is manageable if you have enough money to pay for medical needs.

However, given the proper information on health hazards, the workers are willing to undertake specific actions on their health problems in the workplace. Indeed, there are already a number of workers from thirteen (13) factories who have established their own Union Health & Safety Committee in the factories. They have been active in monitoring health conditions in the factories and have undertaken health skills trainings.

Last year, the Kilusang Mayo Uno (KMU), a militant labor center, set up a Workers' Health Affairs Department. The aim of the department is to facilitate building of local health committees among its militant unions and to uphold the workers' right to health.

In December 1975, the Trade Union Congress of the Philippines (TUCP) concentrated on three areas: seminars on occupational health & safety, acquisition of basic manuals as guides for individual and group actions on health and safety in plants, and research on safety and health conditions in unionized workplaces. Due to economic difficulties the TUCP has set aside the program of health & safety.

After a careful analysis of the workers health situation in the context of the general labor struggle, the Council for Primary Health Care established the Factory-based Primary Health Care (FBPHC) program in 1982. The objective of the program is to improve the working conditions of workers using the primary health care approach. This is being implemented through occupational health research, health trainings, publication of relevant occupational health concerns and providing medical services to workers.

The occupational study being done by the FBPHC staff is participatory in essence. Workers are encouraged to build a Union Health Committee which will carry out a genuine health program for the workers. The Committee is given a comprehensive health orientation prior to the actual training of workers as field-researchers.

The staff alone could not have gained optimal access to the workers and their workplaces. Most requests of the staff to visit the factories were denied by the management. The members of the Union Health Committee proved to be instrumental in doing the surveys. They were given instructions on how to administer the survey forms. This was reinforced during actual surveys where the workers accompanied the staff.

The results of the studies conducted are disseminated among workers' groups in popular form, i.e., pamphlets made accessible and understandable to common workers. This is discussed thoroughly with the Health Committee to plan specific forms of action based on the findings.

It is also the objective of the staff to encourage other private organizations and individual health professionals to utilize their skills and resources in the service of the oppressed and poor workers victimized by health hazards.

Members of the Health Committees are given health skills trainings which are basic in rendering health services to their co-workers. Among the topics discussed are first aid, identification and treatment of common diseases, the normal structure and function of the human body, finger pressure and the proper use of western drugs. Thus, even inside and outside the workplace, the workers are equipped with essential health skills in treating injured and ailing workers.

Recommendations:

1. Strictly enforce existing laws that protect workers' health and safety, Corollary to this, strengthen responsible government regulatory bodies.

2. Repeal and/or amend labor laws and policies that undermine workers' right to health.

3. Amend Rule 1042 to increase workers' participation in health and safety committees.

4. For trade unions, make workers' health and safety a priority concern. Deepen workers' understanding of their rights by expanding labor education to include occupational health and safety.

5. Take positive action to promote and safeguard workers' health such as:
   a) incorporating relevant provisions in collective bargaining agreements
   b) initiating factory-based primary health care programs

6. Heighten the awareness of health professionals and students regarding occupational health hazards and diseases and promote advocacy of workers' rights to a safe and healthy workplace.

In conclusion, we must not forget that the issue of workers' health and safety cannot be approached in isolation with the general struggle of workers which have economic and political inclinations. The workers' uphill struggle to keep body and spirit whole only stands a chance in a society where the rights and welfare of the most downtrodden are given principal attention and action.

In her reaction, Dr. Natividad Chipongian of the Employees Compensation Commission, urged that management, labor and health professionals be educated on occupational health and safety, and that and closer links be forged among themselves.

Expressing frustration over the previous government's inability to crack down on establishments found violating OHS standards, Dr. Wilson Estrada, chief of the labor research division of the labor ministry's (MOLE) Bureau of Working Conditions disclosed the factors responsible for government's apparent neglect in ensuring workers' health and safety.

Many establishments fail to submit OHS reports to the MOLE. In 1983, for instance, only 23 out of 500,000 establishments submitted such reports. He said that there are no penalties imposed upon establishments found violating OHS standards. The inspectorate system, he added, is also severely undermanned.

Under the new government, however, Estrada said that the MOLE's inspectorate system will be improved and penalties will be spelled out to compel management's compliance with OHS standards.

During the open forum, the health group LIKAS (Lingap para sa Kalusugan ng Sambayanan) said that it is working closely with a labor confederation KAMAO (Kristiyanong Alyansa ng Makabayang Obrero) to set up health service cooperatives for factory workers.

The problem faced by the workers in the country on OHS issues also reverberates in developed countries like the United States.

Jim Tramel, a representative of the Massachusetts-based labor coalition on occupational health and safety noted similarities between the Philippine and US labor situation. U.S. trade unions and management are constantly at loggerheads on the composition of health and safety committees, and on the adequacy of personal protective devices. He said trade unions are asking that work sites "be cleaned up" rather than being content that workers be provided with safety devices.

U.S. trade unions have batted for a "workers' only" health and safety committee regardless of whether the establishment they work for has already a joint management-labor health and safety committee.

Labor's insistence that management be made accountable for neglecting occupational health hazards has also borne fruit. He revealed that a Chicago jury has convicted three owners of a factory of murder for willfully exposing workers to hazardous gases that proved fatal.

However, Tramed said that US President Reagan has torpedoed workers' "right to know" clause enshrined in many state laws by passing a federal law that only calls for proper labelling on hazardous substances without giving workers' training in handling substances that may be toxic in nature.

CHAPTER 7

Primary Health Care: Health in the Hands of the People

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I. INTRODUCTION

The Minister of Health Alran Bengzon, in a dialogue with cause oriented health groups last 8 April 1986 remarked that Primary Health Care can be aptly described as "from open mouths and open hands to 'kapit-bisig'". Analyzing this phrase, it intends to say that the present health care delivery is characterized by dole-outs given by health providers and with the recipients, that is, the people literally begging or waiting for services to be delivered to them, and that "kapit-bisig" represents Primary Health Care connoting people working together, displaying their strength in unity, their force and their militancy in response to existing problems in health care delivery.

All of us here in this forum have also our own ideas on what Primary Health Care is all about. What I would like to do today is to present a conceptual framework on Primary Health Care which can be our springboard for discussing the issues that confront the management of Primary Health Care in the Philippines, and thereby provide policy recommendations to make it more effective and efficient.

The framework that I will be presenting has the underlying theme of "Health in the Hands of the People". This was the theme of the First Conference of the Mindanao Non-Government Community Health

Workers held in 1982 in Butuan City organized by the Community Based Health Services-Mindanao and the Health and Development – Mindanao. The Task Force on People's Health has chosen the same theme since we feel, having come from the grassroots workers themselves, it states the most advanced concept of what Primary Health Care is.

Using this concept, even the goal of the World Health Organization of "Health for All by the Year 2000" through the Primary Health Care approach, is already challenged. "Health in the Hands of the People" signifies empowerment of the people in health while "Health for All" just aims for the delivery of health services to all.

This paper will present the rationale of Primary Health Care. This will be followed by a Philippine situationer on Primary Health Care. Next is a review of Primary Health Care Principles and Strategies. The main exposition will be the conceptual framework and matrix illustrating the different levels of people's participation in Primary Health Care. Subsequently, the unresolved issues and obstacles to the implementation of Primary Health Care will be discussed and finally the policy recommendations needed for Primary Health Care will be given.

II. THE RATIONALE OF PRIMARY HEALTH CARE

The Primary Health Care approach has been considered to be one of the major answers to the dismal health situation we have been facing. The highlights of the present health crisis have been well deliberated already during the first forum of this Health Policy Development Consultation Series last 19 March 1986. Nevertheless, it is just worth noting to review the summary findings:

> Health services and facilities are mainly concentrated in urban areas leaving the rural areas very much deprived of health care; Our health manpower are mainly abroad and if they are in the country, they are in the cities; Over-dependency on imported health technologies; the pharmaceutical industry dominated by foreign multinational companies; pre-paid medical insurance limited to the few who are regularly employed.
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> Decision-making in health mainly top to down with minimal participation of the majority; Health priorities have been given to building disease palaces; Water and sanitation, control of communicable diseases, maternal and child health care given

minimal support; The health ministry's share of the national budget has been very small. The health budget spends more for curative care than preventive health care.

Values, beliefs and attitudes in health remain colonial, elitist and feudal. Health manpower education continue to be Western oriented. Poor motivation of government health personnel due to low pay and poor working conditions.

This deplorable health situation is largely the result of poverty. It is an irony that in a country with an abundance of natural wealth, the majority of our people are suffering and dying of diseases linked with poverty. Eventually, discussing the poverty issue will also bring out the inter-relationship of main health problems to the issue of foreign domination of our socio-politico-economic life, the unequal distribution of land and wealth in society and the corruption that thrives in the bureaucracy.

It is within such a situation and background that health care providers are challenged to do something to bring about a more just and relevant health system. This has been the rationale for the development of the Primary Health Care approach. Let it be now clarified that Primary Health Care is an approach and not a program. Primary Health Care is also different from the term primary level of health care, or first contact, as it is used in the health referral system.

III. A PHILIPPINE PRIMARY HEALTH CARE SITUATIONER

The Primary Health Care approach has been practiced in the Philippines even before the 1978 WHO Alma Ata Declaration. Most of the practitioners came from the private sector who were either in hospitals and clinics, health organizations or academic institutions. A few examples of these were De la Paz of the Katiwala Program in Davao City, Viterbo of Roxas City, Macagba of La Union, Flavier of the Philippine Rural Reconstruction Movement, Campos of the University of the Philippines Comprehensive Community Health Program, Solon of the Paknaan Club Institute of Medicine Project and Wale of Siliman University. These doctors were already reaching out to the community since the late 60's. However, their efforts were limited in their own territories and they were not able to extend their programs on a national level.

It was only when the Rural Missionaries of the Philippines launched their pilot community-based health programs (CBHP) in 1975 that a nationwide movement started to be felt. The Rural Missionaries first studied the prototypes mentioned earlier and using the Catholic Church network, initiated programs in Luzon (Isabela), Visayas (Leyte) and Mindanao (Lanao del Norte). Their experiences were eventually adopted by the National Council of Churches in the Philippines (Protestant Churches) in 1977 and by AKAP (secular) in 1978, both of them establishing their nationwide network. At present, these Community Based Health Programs have their national and regional coordinating bodies. The Council for Primary Health Care takes care of the national coordination, the CHESTCORE for the Cordilleras, CBHP-Ilagan for Cagayan Valley, the Health Integrated Development Services (HIDS) for Central Luzon, the MAKAPAWA for Leyte and Samar, the Visayas Primary Health Care Services for Cebu and Bohol, the Negros CBHP Coordinating Body for Negros Island, CHARGE for Panay Island, the Community Based Health Services for Mindanao and the Urban Missionaries and KAPPAG for the Metro Manila area. The CBHPs are in 40 provinces with around 200 health personnel as staff and an estimated 3,000 active Community Health Workers as volunteers.

On the government (Ministry of Health) side, a Research and Development in PHC was started in 1978 with WHO/DANIDA/Sida technical support. But even before this, in 1973-74, there were also regional initiatives in PHC, to name a few, Banzon of Region VIII with the Barangay Health Auxiliary Volunteers and Roxas of Bukidnon with the Barangay Volunteer Medics. However, it was only in 1981 when the nationwide implementation of PHC started. As of 1985, according to MOH documents, the "Primary Health Care approach is officially working in all barangays except for one percent of these wherein there is unstable peace and order situation." Their Barangay Health Workers number 365,941 with a ratio of 1 BHW for every 20 households. A total of 14,718 Botica sa Barangay have been established, with an almost equivalent number of pharmacy aides trained to man these village pharmacies.

These listings are by no means complete. There is no doubt that there are a lot more private voluntary groups and government bodies that have been doing a lot of Primary Health Care work quietly and effectively. We hope we will be able to identify them in the immediate future.

IV. PRIMARY HEALTH CARE PRINCIPLES AND STRATEGIES

Let us therefore now review the different principles and strategies that have been employed by various Primary Health Care practitioners. These have been culled from written literature of both government and non-government groups.

Principles	Strategies
1. Accessibility, Availability and Acceptability of Health Services	1.1. Health services delivered where the people are; 1.2. Use of indigenous/resident volunteer health worker as health care providers; with a ratio of one community health worker per 10-20 households; 1.3. Use of traditional (herbal) with essential drugs.
2. Provision of quality, basic and essential health services	2.1. Training design and curriculum based on community needs and priorities, task analysis of community health workers (CHW) and competency based; 2.2. Attitudes, knowledge and skills developed are on promotive, preventive, curative and rehabilitative health care; 2.3. Regular monitoring and periodic evaluation of CHW performance by the community and health staff.
3. Community Participation	3.1. Awareness building and consciousness raising on health and health related issues; 3.2. Planning; implementation, monitoring and evaluation done through small group meetings (10-20 household cluster): 3.3. Selection of CHW by the community; 3.4. Community building and community organizing;

	3.5. Formation of health committees;
	3.6. Establishment of a CHW organization at parish/municipal level;
	3.7. Mass health campaigns and mobilizations to combat health problems.
4. Self-reliance	4.1. Community generates support (cash, kind, labor) for the health program;
	4.2. Use of local resources (human, financial, material);
	4.3. Training of community in leadership and management skills;
	4.4. Incorporation of income generating projects, cooperatives, small scale industries
5. Recognition of the interrelationship between health and development	5.1. Convergence of health, food, nutrition, water, sanitation, population services;
	5.2. Integration of PHC into national, regional, provincial, municipal, barangay development plans,
	5.3. Coordination of activities with economic planning, education, agriculture, industry, housing, public works, communication and social services.
6. Social Mobilization	6.1. Establishment of an effective health referral system;
	6.2. Multi-sectoral and inter-disciplinary linkages;
	6.3. Information, education and communication support using multi-media;
	6.4. Collaboration between government and non-government orgs.

7. Decentralization	7.1. Reallocation of budgetary resources;
	7.2. Reorientation of health professionals re: PHC;
	7.3. Advocacy for political will and support from the national leadership down to the barangay level.

V. THE FOUR LEVELS OF PEOPLE'S PARTICIPATION IN PRIMARY HEALTH CARE

The core principle of Primary Health Care is people's participation. Its presence sets it apart from the other approaches to health care. This is the main reason why I would like to focus on this particular principle as the underlying theme of the conceptual framework on Primary Health Care. To be presented now is a matrix describing four levels or models of people's participation in Primary Health Care: These are the Hospital/ Clinic Based Level/Model, the Community Oriented Level/Model/, the Community Based Level/Model and the Community Managed Level/ Model. The matrix would serve as a basic framework for describing and analyzing the current status of Primary Health Care in the Philippines whether these are managed by the Ministry of Health or by non-government organizations. The question to ask while one goes through the matrix is: What level or model do the existing Primary Health Care Programs belong or fit into?

(Please see attachment for the matrix on the 4 Levels of People's Participation in Primary Health Care)

A particular PHC program need not necessarily fit exactly into any one level. One can look at these levels as a continuum and are not mutually exclusive of each other, where a PHC program have qualities of one approach in a specific category and have also another quality in the next approach in a different category. For example, a PHC program may be already community based in the category of initial objectives but is still community oriented in terms of monitoring and evaluation. As one will notice, it is in a community managed Primary Health Care program where "Health in the Hands of the People is fully achieved."

THE FOUR LEVELS/MODELS OF PEOPLE'S PARTICIPATION IN PRIMARY HEALTH CARE

CATEGORIES	HOSPITAL/ CLINIC BASED	COMMUNITY ORIENTED	COMMUNITY BASED	COMMUNITY MANAGED
GUIDING PRINCIPLE	Health *to* the People	Health *for* the People	Health *with* the people	Health *by* the people
MAIN CHARACTER	Authoritarian	Paternalistic	Democratic	Liberating
INITIAL OBJECTIVES	Rigid and statistic oriented	Closed and pre-determined; defined before community is consulted	Open ended and flexible; problems and needs evoked from the community	Formulated by the community & based on their felt needs; vision of an alternative social order expressed by the people
TACIT OBJECTIVES	Maintain status quo; perpetuate existing health system	Improve/alter certain aspect of the health system	Transform the health system and initiate social reforms	Complete re-structuring of the health system together with socio-economic transformation
WHO IS RESPONSIBLE FOR HEALTH?	Health is the sole responsibility of the doctor	Health is the responsibility of health professionals	Health is the responsibility of community health workers and leaders	Health is the responsibility of everyone in the community
OUTLOOK OF HEALTH PROFESSIONALS	As recipients of health care	As beneficiaries of a health program	As partners in health care	As managers of their own health program

LEVEL OF COMMUNITY PARTICIPATION AND MAIN DECISION MAKERS	Community is just informed of health activities	Community is just consulted on what can be done Doctors and other health professionals decide.	Community actively discussed & decides on plans & activities together with health professionals Decision making shared by community and health staff.	Community identifies needs, define objectives, plans, implements, monitors & evaluates the health program on their own. The community is the main decision maker.
VIEW ON AWARENESS BUILDING	The community should be kept ignorant of health	Community is made aware to change their behavior or to pacify them if their hardship drive them to revolt	As a menas for community organizing and for understanding the inter-relationship of health to the economic, political and cultural problems	As a means to generate people's power and ensure continuing community participation
VALUE GIVEN TO COMMUNITY ORGANIZING	The community is not capable of being organized	As a means to change people's attitudes to cooperate with health authorities whole-heartedly	As an end in itself and as an opportunity for people to develop leadership and management	As the main tool for empowerment and as a long lasting safeguard to protect the community's interest

CATEGORIES	HOSPITAL/ CLINIC BASED	COMMUNITY ORIENTED	COMMUNITY BASED	COMMUNITY MANAGED
DATA GATHERING MONITORING AND EVALUATION (M & E)	Data limited to morbidity, mortality & health services statistics	Data gathered by outsiders via a long survey questionnaire with heavy emphasis on health data	Data gathered by community health workers & kept simple; includes people's felt needs & concerns Collation & analysis done together with health staff.	Community decides what data to collect. Community members gather, collate & analyze data on their own. Self-evaluation & self-monitoring systems established. Community members continuously informed of data gathered & relevant actions taken accordingly by them
	M & E mainly the concern of hospital/ clinic management. No feedback of information to clientele or community	M & E done by health staff Little or minimal feedback of information to the community	M & E done jointly by community health workers and health staff. Regular feedback given to community	

INTER-SECTORAL LINKAGES & SOCIAL MOBILIZATION	Believes that they are doing their work sufficiently thus there is no need for linkages	Usually limited to government agencies or to those who give dole-outs	With any agency, government or non-government who maybe of assistance in giving solutions to health & other issues	With organizations & institutions working for basic societal changes. Forms alliances & federations with them.
EFFECT ON THE PEOPLE AND THE COMMUNITY	Oppressive - rigid central authority allows little or no participation by the community	Deceptive - pretends to be supportive, allowing some participation but resists genuine change	Supportive - helps people find ways to gain more control over their lives	Self-reliance & self-determination. People aware of their potentials & uses them to the full and with responsibility.
GENERAL IMPACT	No change	Behavior change	Social change	Structural change

VI. A COMPARISON OF PHC MANUALS FOR COMMUNITY HEALTH WORKERS

To further analyze up to what extent "Health in the Hands of the People" is being advocated and put into practice, let us look into two Primary Health Care Manuals for Barangay/Community Health Workers. These are the: Primary Health Care Household Teaching Manual produced by the Ministry of Health with copyright 1983 and revised 1985 and Our Health Our Lives, a Philippine Health Manual for Community Workers produced by the National Ecumenical Health Concerns Committee of the National Council of Churches in the Philippines with copyright 1982.

These two manuals were chosen because both of them have had already national distribution, both of them have been translated into the major Filipino languages and both of them are being used by two major groups involved in Primary Health Care.

Going now to our analysis, the first question to ask is: How do the two manuals deal with the number one leading cause of death and disease in the Philippines – pneumonia?

> The Household Training Manual does not mention anything at all about pneumonia. The word "pneumonia" does not even appear in the Manual. Our Health Our Lives discusses what is pneumonia, its signs and symptoms, prevention, treatment and complications.

The second question: How do the manuals tackle tuberculosis, the most prevalent chronic communicable disease in the country (also a leading cause of morbidity and mortality)?

> Both manuals tackle tuberculosis discussing its definition, signs and symptoms and its prevention. It is with regards to diagnosis and treatment where the two manuals differ in presentation. The Household Teaching Manual tells about sputum collection and fixing the sputum in a slide but does not explain it in a step by step manner. Our Health Our Lives includes illustrations and instructions sequentially and even goes to explain how to do an acid fast stain of the sputum. As to TB treatment, the Household Teaching Manual does not mention any drugs while Our Health Our Lives mentions 3 drugs, its use, precautions and available preparations.

Even with just these two important questions, we already see the strengths and limitations of the two manuals in achieving "Health in the Hands of the People."

Let me also mention the other positive elements that both manuals contain. Both use simple language and plenty of illustrations. Both contain a balance of promotive, preventive and curative information, giving emphasis to the maintenance of health at the personal, family and community levels; maternal and child health, family spacing, nutrition, control of diarrheal disease, sanitation, first aid and mental health.

The advanced features of the Household Teaching Manual are: it contains learning objectives, learning activities and questions for evaluation for every topic discussed; it has guidelines for organizing household study groups, principles of adult learning, how to be an effective communicator and team building exercises.

Our Health Our Lives, on the other hand is advanced in terms of providing skills on history taking and physical examination, care of the sick, common signs and symptoms, anatomy, physiology and pathology of the different body systems, Western drugs, acupuncture and laboratory procedures.

VII. UNRESOLVED ISSUES IN THE MANAGEMENT OF PRIMARY HEALTH CARE

Despite years of practice of Primary Health Care, there are still a number of issues that remain unresolved. These issues I would like to term as "pseudo" issues, and not real issues, in the sense that they continue to remain unresolved mainly because there is still a lack of appreciation of what Primary Health Care really is especially in its core principle of people's participation. These are mainly issues that crop up with the government's implementation of a nationwide Primary Health Care Program.

1. Volunteer vs. Paid Barangay Health Worker

Although the pilot PHC programs have shown the failure of using paid Barangay Health Workers (BHW), the debate continues on whether to pay or not to pay BHWs. The issue becomes more pronounced when the number of active/inactive BHWs are reported over time and this shows an increasing number of inactive BHWs. One common reason given for drop-outs of BHWs is the lack of monetary incentives and therefore a recommendation is to provide incentives for BHWs. The Ministry of Health knows that it cannot provide monetary rewards

because of administrative and financial constraints. Last December 1985 though, BHWs were given benefits in terms of free hospitalizations and medicines which extend to their immediate family. A size issue to this is if the government pays the BHW, to whom does the BHW owe his loyalty – to the Ministry of Health or to his barangay?

For non-government PHC programs, this is not so much an issue mainly because of financial constraints also. They have managed however to retain a stable number of active Community Health Workers (CHW) through the years due to their heavy input on attitudinal and value formation during the CHW training, the building of a strong grassroots community organization and the activities and income generating projects. The challenge given to NGOs by government is that if the NGOs were given the opportunity to go on nationwide scale, would they be able to sustain BHW activity through the mechanisms that they have employed in a small scale?

2. Use of Pharmaceutical Drugs vs. the Use of Herbal/Traditional Medicine in the Botika as Barangay Project

The Ministry of Health has both of these 2 elements present in their Botika sa Barangay Project. Although Ministry officials will say there is no conflict between the two elements, visits to the Barangay level have shown contradictions in the implementation of the Botika sa Barangay Projects. Most Botika sa Barangay still sell anti-diarrheal drugs instead of promoting oral rehydration therapy or herbal medicine. These Botikas even sell banned drugs (the most common are analgesics containing dypirone). The village pharmacy aide training does not include skills in herbal medicine use nor awareness on banned drugs. There has to be clearer implementing guidelines for the Botika sa Barangay e.g. stand on banned drugs, use of generics or sticking to a list of essential drugs, or herbs with proven efficacy should already be sold in place of Western drugs.

3. PHC Committees vs. Nutrition Committees

The implementing guidelines for PHC say that PHC Committees should be established at all levels, from the national to the barangay level. The implementing guidelines for the Philippine Food and Nutrition Program also state that Nutrition Committees should also be established at all levels. So we have PHC Committees and Nutrition Committees, each with its own vertical administrative lines. Some municipalities and barangays have resolved the issue by merging the two committees into one for pragmatic reasons, although they still provide

separate reports to the Ministry of Health and to the National Nutrition Council. However, for the majority, the issue still has to be resolved. Either that the national bodies concerned meet and decide on a common guideline or the Regional/Provincial Development Councils be given the power to decide on the merger.

4. Multi-purpose Barangay Worker vs. Barangay Health Worker

This is related to the preceding issue mainly because as more and more line agencies get to the barangay, there are more and more different types of barangay volunteer worker being developed. So there is a Barangay Nutrition Scholar of the National Nutrition Council, the Barangay Service Operation Point of the Population Commission, the Barangay Health Worker of the Ministry of Health, the Day Care Worker of the MSSD or the SEA-K (Self-Employment Association Kalusugan) volunteer also of the MSSD. Generally, one would find out that only one person would represent all or some of these functions in the barangay. The problem is that this single person has to fill up so many forms, one or more from each agency, and usually asking the same kind of data information. There must be a way for all of these different agencies to meet to discuss on how they can streamline their operations at the barangay level – for example, the use of a single reporting form, the use of multi-purpose barangay volunteer workers, the convergence of services to the barangay.

5. Vertical vs. Horizontal Programming or
Centralized vs. Decentralized Decision-Making

Primary Health Care is essentially a horizontal program and therefore requires decentralized decision-making. However, in practice, we still see a lot of verticalism and centralized decisions being made. For example, implementing guidelines are so rigid that there is no room for flexibility in areas where such guidelines may not apply. The targetting, quota system (e.g. number of BHWs trained, number of patients seen) stifle the creativity and lose the relevance of a particular activity at the peripheral level. The whole issue of decentralization is of course a macro issue that has to be dealt with at the national level if we really want to have meaningful grassroots participation.

Non-government organizations involved in PHC have been more adaptive, flexible and creative (to try innovative approaches) mainly because of ther decentralized systems of function. For example, Community Based Health Programs in different provinces have their own sources of funding (instead of a centralized one); even though there

maybe regional/national coordinating bodies, each program area has its own autonomy in setting its objectives, planning their activities etc. Guidelines from the national or regional bodies remain as guides and not as something compulsory to be followed.

6. Up to What Level of Knowledge and Skills Should a Barangay Health Worker be Trained?

Non-government organizations would answer this by saying that it depends on the identified needs of a particular community. If a community sees the need for training on antibiotic therapy or giving of streptomycin injections because it takes them 7-10 hours travel to reach the nearest health facility, then they would provide training to answer such need. For them, this is the rationale for having a flexible training curriculum for CHWs.

The Ministry of Health would say that their rural midwives are in place and that the role of the Barangay Health Worker is just to assist the midwife and provide promotive and preventive health activities with limited curative skills. The BHW can always refer to the midwife cases he/she cannot handle.

If we are to follow the theme of "Health in the Hands of the People", then it means equipping and empowering the Barangay Health Worker and the community to respond to their health needs. To implement this on a national scale, I would propose a system wherein the Barangay Health Worker would have a gradation of knowledge, attitudes and skills to be developed over time. The elevation of a BHW to the next level of skills would depend on his previous performance as evaluated by the community. It would be some sort of a ladder type of curriculum, only this is in a non-formal education setting with no academic degrees granted. This would provide a continuing incentive for both the BHW and the community to give their support to the PHC program.

7. Foreign Loans vs. Grants/Reallocation of Resources

The Ministry of Health has utilized Population Loan I and Population Loan II from the World Bank. The difficulty with these loans is that the Ministry was tied down to certain agreements imposed by the World Bank. Population Loan I funded the restructuring of the health care delivery system (1974-79) wherein we witness the allocation of ambulace vehicles to areas where there are no roads (Samar) or the

construction of rural health units beside hospitals/clinics (Kalinga) or the constructions of regional/provincial hospitals in front of already existing private hospitals (Cotabao and Tawi-Tawi), Population Loan II gave us the expensive AKO (Ang Katawang Okey) Health Campaign wherein we still ask whether such a campaign really improved the health status of the Filipino. There should be a rethinking whether we should continue to accept these kinds of loans or the Ministry should continue to accept these kinds of loans or the Ministry should just accept grants with no strings attached or the the more self-reliant path of reallocating of resources for health.

VIII. OBSTACLES TO PRIMARY HEALTH CARE IMPLEMENTATION

Though Philippines is a signatory to the Alma Ata Declaration and has made the commitment to implement Primary Health Care nationwide, there are still obstacles which hinder its full implementation. I see a legal impediment and a stumbling block posed by our medical/nursing/dental/midwifery educational system.

1. The legal obstacles. The national government still has to amend the medical act, the nursing act and midwifery law (for nurses to be allowed to practice some form of medicine i.e. nurse practitioner, for midwives to perform some nursing functions etc.) Legally, the midwife is not allowed to give injections nor immunizations. This has hampered the implementation of the expanded role of the midwife. This is particularly true in the urban setting. And there are still no laws to protect a Barangay Health Worker who is doing medical, nursing or midwifery functions.

2. The educationl obstacles. The medical, dental, nursing and midwifery curricula are still Western oriented and primary health care, preventive and promotive health are just given lip service by our health education institutions. Just a look at the number of hours given to community medicine/nursing or public health compared to the total number of hours given to hospital/curative work is enough evidence that Primary Health Care is just a token in the training of our health professionals. The U.P. Institute of Health Sciences in Region VIII has proven that a medical/nursing/midwifery curricula can be designed to have 50 % of its training time for community practice and 50 % for hospital practice and didactic lecutures, and still produce board qualified doctors, nurses and midwives. It is still not yet too late to start an overhaul of our health manpower curricula.

IX. POLICY RECOMMENDATIONS FOR PRIMARY HEALTH CARE

In the light of our discussions, the following policy recommendations are made for Primary Health Care:

1. Make Primary Health Care the centerpoint for policy and program development in health. Utilize Primary Health Care as a comprehensive and integral approach and principle to guide policies in drugs, hospitals, health manpower education, health care financing etc.

2. Launch a national review of Primary Health Care policies, plans and implementation, by creating a Task Force on Primary Health Care whose aim is to evaluate its present status and its implications to our National Development Plans. Ensure substantial participation of non-government organizations in this Task Force.

Open Forum

"Because every individual is different, every community is different," explained Dr. Manuel Roxas, deputy minister for health services in his keynote speech. 'They can solve their own problems more than we at the top because they are the ones concerned," he added.

As Filipinos, continued Roxas, "I think we can be masters of our own fate, masters of our own destiny. We can chart our own futures. We should not wait for other countries to help us. . . We should make our own programs for our own selves, for our own country."

Reacting to Tan's lecture, Dr. Flora Bayan, PHC coordinator of the Ministry of Health, observed that primary health care in smaller units costs less in implementation compared with the high costs of instituting it on a nationwide scale. It was suggested that autonomous units could be a more viable solution.

Dr. Pia Malanyaon of LIKAS recalled that under the Marcos regime, organizing for PHC among the grassroots was dangerous as they frequently came under suspicion for alleged subversive activities.

There should be no limit to what barangay health workers (BHWs) can be taught, she said. She also observed that BHWs must receive some kind of remuneration in cash or in kind as an incentive to continue their services. This can be generated by the people themselves.

The implementation of primary health care in an urban setting requires a different approach, health services being readily available but not affordable, Malanyaon said. Strategies would include cooperatives of insurance type ventures among urban workers.

Tan commented that in an urban slum setting, community-based health programs (CBPs) should focus on social mobilization and intersectoral linkages.

Dr. Ledevina Carino, of the UP Institute of Public Administration, suggested that another column be included in the matrix entitled "hospital/clinic-oriented." This designation would refer to primary medical care being dispensed by a clinic or hospital with a bare minimum of community participation.

Carino noted that as one moves from left to right, the chart develops from individual approaches towards community approaches so that finally, in the community-managed level, the definition of being healthy is that healthiness (i.e. being healthy) is shared by every member of the community.

Carino said that this is also paralleled by moving from a complete reliance on Western technology toward a testing of the efficacy of other available technologies blending with what has been found useful.

Non-government organizations and the government must work complementarily rather than compete, Carino also said.

CHAPTER 8

Strengthening Maternal and Child Health

Natividad R. Clavano

THREE M's

(1) Increased Morbidity
(2) Increased Malnutrition
(3) Increased Mortality

RATIONALE FOR MATERNAL AND CHILD HEALTH PROGRAMMES

1. The mother has too much share of responsibility for the family but too small a share in the decisions.
2. Maternal depletion – too little food with too many pregnancies.
3. The mother is at the "centre" of her children's health and survival which can be heavy load for her.
4. Too short a time to accomplish the household duties in 24 hours.
5. The heavy burden of the 3 M's of her children.
6. Too short maternity leaves.
7. Too low salary for her work.

GAPS IN THE PROVISION OF MCH SERVICES

The mother and the child should be the focus and recipient of all the activities of health manpower, other allied agencies and NGOs.

While the health services are essential, they are not enough. The powerful tools, methods, activities, services available to reduce the 3 M's in the mother and child trickle down only in small amounts. The key to close the gap is the return to the family of the primary responsibility to actively participate to promote their own health.

Country Profile

Population:	53.3 million (1984)
Urban:	39 % (1983)
Rural:	61 % (1983)
Crude Birth Rate (CBR):	31/1000 population
Newborns:	1.6 million
Infant Mortality Rate (MR):	50/1000 NB
Surviving Infants:	1.56 million
No. Women (15-45):	10.5 million

CONTROL OF DIARRHOEAL DISEASE PROGRAMME, MINISTRY OF HEALTH

History

The present national CDD programme with its emphasis on the widespread use of Oral Rehydration Therapy (ORT), can be said to have its origins in the Cholera Research Project (1964-1972) and the ORT studies conducted between 1975 and 1977. These pioneer studies were of world-wide importance in demonstrating the value of ORT. The beneficial effects of ORT shown by the field studies led to pilot implementation in each of the country's health regions.

Introduction

The Ministry's programme on the Control of Diarrhoeal Diseases (CDD) was started in late 1980. The programme has 2 objectives: (1) the reduction of mortality from diarrhoeal diseases particularly among children less than 5 years old through the extensive

use of Oral Rehydration Therapy, and (2) the reduction of morbidity from diarrhoeal diseases particularly among children less than 5 years old by strengthening the components of maternal and child health, environmental sanitation, nutrition service and surveillance/epidemic control. CDD is now implemented in all of the MOH hospitals (367), rural health workers (1991), barangay health stations as well as botica sa barangays or village drugstores (14,632). Barangay health workers (214,696) also participate in use of ORESOL along with other Primary Health Care (PHC) activities.

The provinces chosen for the review were La Union in Region 1, Bohol in region 7, and Bukidnon in Region 10.

Programme Targets

The targets established for the objectives of the programme in 1980 are:

- to reduce diarrhoea mortality in children by 75 % by the end of 1987
- to reduce diarrhoea morbidity in children by 50 % by the end of 1987

Problems

Case Management

- There is still over-use of anti-diarrhoeals, anti-biotics and intravenous fluids for diarrhoea treatment.
- Some doctors do not use ORESOL; most private practitioners have no access to ORESOL.
- Clinical assessment of cases tends to be inadequate, and ORT is not used properly.
- The programme has not yet formulated a clear policy on the use of home-prepared fluids to prevent dehydration.

ORESOL Supply, Storage and Distribution

- The need to import raw materials for ORESOL production has resulted in interruption in production and increasing cost.

- Distribution of ORESOL sometimes suffers from inadequate funds.

- Packing cartons cannot withstand repeated use or long-term storage.

- There is some spoilage of ORESOL packets in some RHUs and BHSs.

Training

- The quality of training in clinical management is not yet adequate because of lack of qualified trainors and supervisors.

- There is not enough emphasis on non-ORT strategies.

- National and regional ORT training centers are not yet fully functional.

Non-ORT Strategies

- At all levels, non-ORT strategies seem to be taken for granted by the programme and consequently prolonged breastfeeding, weaning and child care practices, personal hygiene and food safety do not receive much attention.

Recommendations on the impact usage and promotion of Oral Rehydration should provide a clear policy on home-base formulation of salt, sugar and water. Alternatives like the possibility of using cornstarch or rice startch or lugao instead of sugar when it is not available should be considered.

To improve training skills, production and distribution of ORESOL is another venue. More coordination betweent the Ministry of Health and the private sector is needed. Most important is the knowledge on how and when to use Oral Rehydration. Therapy must now be put at the disposal of millions of parents all over the Philippines.

Immunization

The ultimate goal of immunization is to prevent death in children and the global target is immunization for all by 1990.

If vaccines are to play their vital part in bringing about a revolution in child survival and development, then immunization mut be made available in practice and not just in theory. And that means taking into account the poverty of circumstance, the lack of information, and the unfair burden of work which effectively deprive many women of the power to protect their children by immunization.

The preliminary findings of the Comprehensive Programme Review of the Expanded Programme on Immunization (14 April - 13 May 1986) undertaken jointly by UNICEF/WHO/MOH:USAID/ROTARY INTERNATIONAL/SAVE THE CHILDREN (UK) revealed that only 25 % of immunizable children are fully immunized against tuberculosis, diptheria, pertusis, tetanus, polio and measles.

Empowering parents with information about what immunization offers will reduce the risk of child death. Second, immunization should be available at times and places more convenient to working people can reduce the distance which parents need to travel. Both bring immunization nearer.

Such programmes are characterized by two principles: (1) provision of the services at a convenient location nerar the residence of the recipients and at a convenient time; (2) active promotion of the service being offered.

Immunization should be offered at conveneient assembly points which are not too distant provided that the programme is well organized and promoted. Remarkably, high levels of acceptance have been achieved when educational and promotional methods have been imaginative.

Vitamin A

Lack of Vitamin A in the child's diet, long known to be a cause of xeropthalmia and eventual blindness, confirmed a long-held suspicion that it is also an important determinant of a child's overall health.

But further analysis has suggested that otherwise well-nourished children who lack Vitamin A are more prone to both diarrhoeal and respiratory illnesses than are poorly nourished children but who happen to have adequate levels of Vitamin A.

In the one major test of the practical significance of these findings, it appears that distribution of the standard UNICEF Vitamin A capsule every six months has succeeded in reducing child death rates (in the age group one to three years) by approximately 30% among a population of over 15,000 children in Indonesia.

Promotion of Breastfeeding

In both developed and developing countries today, health workers and scientists are coming to recognize the immense health benefits which are being denied to countless infants whose main, if not sole, source of nutrition is powdered milk formula. They are denied these benefits because they are denied a rich source of protection and nutrition – breastmilk. In many different parts of the world, substantial evidence has established both the direct and indirect relationship of breastfeeding to lower rates of illness, death, and malnutrition among children.

First of all, breastmilk is a perfect infant food, providing babies with complete, balanced nutrition. It is also a fluid with living cells which are constantly changing and adapting to the immunological and nutritional needs of the baby. It has been found, for example, that the breastmilk of mothers of premature infants has a higher concentration of proteins and immunoglobin A than the milk of mothers of full-term infants. This natural phenomenon is vital to the growth, protection and survival of the premature infant, whose need for protein and immunological protection is greater.

A second natural miracle of breastfeeding is the 'homing mechanism' which enables mothers to produce and transmit to their babies through breastmilk, antibodies against infection.

Breastmilk initially appears as colostrum, a concentrated yellowish fluid measuring approximately 25ml during the first 24 hours. The small amount and strange colour of the milk at this stage misleads many health workers and mothers into feeling anxious that the mother's own milk might not be enough to feed the baby. Because of this, many women resort to prelacteal or supplemental formula. The result is less sucking and therefore less breastmilk supply. In many cases, this process ends in breastfeeding being abandoned altogether.

In some cultures, colostrum is considered dirty and stagnant and is deliberately expressed and discarded. Some mothers discard only the first few drops of colostrum while others discard all the colostrum for

three days. Meanwhile, the child is usually fed on sugar and water or on infant formula and is thereby deprived of the anti infective cellular components in the colostrum which engulf and kil virus, bacteria and fungi. Colostrum also contains proteins, 65 % of which are anti-microbials. In the mature milk, these immunological qualities of colostrum are present in lesser concentrations. In addition, breastmilk has also been found to contain taurine in quatitites 30 to 40 times greater than in infant formula. Taurine is essential to the development of brain cells.

A third advantage of breastfeeding is its contraceptive effect. The prolactin which is released into the mother's body by the act of suckling inhibits the return of ovulation and significantly reduces the likelihood of prenancy. According to some estimates, more pregnancies are prevented by breastfeeding than by all other forms of contraception put together. So although lactation is not a reliable form of family planning from the individual mother's point of view, there is now no doubt that the overall effect on a society is to lengthen the interval between births, lower total family size, and reduce population growth.

Anything which interferes with the intensity, frequency and duration of the child's suckling may therefore diminish the many different kinds of protection which breastfeeding provides. And of such threats, the greatest is the trend towards bottlefeeding with infant formulas.

It is a threat which operates in two ways. In place of the nutritional and immunological protection of breastfeeding, bottlefeeding with artificial formula substitutes the risk of malnutrition from over-diluted milk powder and of infection from unclean water and feeding equipment. Secondly, bottle-feeding has an indirect effect on child health through its contribution to shorter birth intervals and larger family size – both of which are known to be correlated with increased malnutrition, illness, and death among the world's infants.

In spite of the many attempts to fully understand the biological, nutritional, anti-allergic and other protective properties, as well as the psychological benefits which can be derived from breastfeeding, there are still more protective and nutritive qualities of breastmilk which need to be discovered. It will probably take another decade to fully appreciate all the benefits of breastmilk – benefits which neither man nor machine can duplicate. Breastmilk itself is still an enigma.

Most of this research is relatively recent. But already, it has led to a lage-scale return to breastfeeding in the industrialized nations, where this knowledge has been disseminated and where the proportion

of mothers using commercial infant formula has previously risen to as high as 75 % in some countries. Unfortunately, the earlier decline of breastfeeding in the developed nations has set an example which is still being followed in many other countries of the world. In traditional societies, breastfeeding was accepted as the only norm for the baby's survival. But as technology and modern ways encroach on feeding methods and other habits, breastmilk is eventually abandoned in favour of bottle-feeding. In the Philippines, the trend away from breastfeeding has been very pronounced throughout the urban community. A WHO study, for example has shown that one third of mothers from economomically advantaged backgrounds never even tried to initiate breastfeeding, while in the urban poor community one sixth of the mothers interviewed indicated that they had never breastfed. Furthermore, 27 % of the mothers from the urban economically advantaged group, 9 % of those from the urban poor, and 41 % of those from the rural population were found to have been given free milk samples while in the hospital.

But one of the main reasons why so many women have abandoned breastfeeding is the example set by hospitals themselves. Another has been the promotion of artificial milk by many commercial companies – fortunately a now declining number – and especially the giving away of free samples of milk powder to new mothers in hospitals and health centres. In most hospitals in the Philippines especially in the urban areas, newborn babies are separated from their mothers at birth, confined to nurseries, and initiated to the taste of powdered cow's milk several hours after birth – even before their mothers have a chance to breastfeed them. This is the way we bring children into the world.

If such policies in health units are allowed to persist, then we, the health workers, have become the tool of the offending companies in their vigorous marketing campaigns.

Can we allow this to happen in our midst? Are we willing to counter these milk companies' multi-million dollar campaigns with all the effort we can muster to return babies back to their mother's breast for survival and health?

Under-Six Clinic Programme

Each Filipino child 0-6 years old by the year 1990 should be provided for with a home-base growth chart.

The thrust of the programme is to introduce a comprehensive health package for 0-6 year old children and to provide optimum, preventive, promotive and curative health care through a series of consulta-

tions with the children/parents. The main concern of the programme is to reduce mortality, morbidity, malnutrition and to ensure healthy Filipino children.

To attain this objective, innovative approaches in the delivery of health care for 0-6 year old children are employed, e.g. comprehensive health care by the use of the home-based growth chart to monitor growth and development, detect Anemia, prevent and correct dehydration through Oral Rehydration, provide immunization to children, encourage birth spacing, advise proper Nutrition (breasfeeding, food supplements, Vitamin A supplementation) and treat acute and chronic illnesses.

For inception of the programme, the following have also been promoted and implemented: Rooming-in and Breastfeeding within 30 minutes after birth; Mother and Child Room; Human Milk Banking and Wet Nursing. All concepts are designed to totally eradicate formula/bottlefeeding in the maternity ward and nursery. A Rota system of health teaching is adopted so that parents may actively participate in the care of their children.

And because it is a regular activity, bringing mothers and children into monthly and predictable contact with community health workers, growth checking provides the ideal opportunity for beginning to build community-based primary health care. It can provide for example practical focus for the demonstration of how and when to make and use an oral rehydration solution. It can also provide a forum for the visit of an immunization team or for the distribution of Vitamin A supplements. It can be the activity through which to supply parents with chloroquine or anti-parasitic drugs. It can be the opportunity for parents themselves to discuss their own concerns and priorities.

Rota System of Health Teachings in the Baguio Under-Six Clinic

January	– Pre-natal Care
February	– Care of the Newborn
March	– Breastfeeding
April	– Immunization
May	– Environmental Sanitation
June	– Communicable Diseases
July	– Feeding a Child
August	– Home Management of Simple Illnesses
September	– The Growth Chart
October	– Malnutrition Infection
November	– Family Planning
December	– Services of the Under-Six Clinic

As of 1985, there are now 400 trainors who have undergone training to conduct their own echo seminars. The programme has also graduated 4,000 trained implementors who have completed the theoretical and practical requirements of the Under-Six Clinic Seminar Workshop Course.

To date, there are more than 2,000 Under-Six Clinics throughout the country serving more than two million under-six clinic registrants.

Some medical universities, midwifery and nursing schools have incorporated the methodology and implementation of the Under-Six Clinic in their curricula.

Most heartening is the initiative and cooperation of these trainees, factors which have brought the programme to the Visayas, Mindanao, and throughout Luzon. The encouraging news, therefore, is that, in its way, the Under-Six Clinic programme, under the combined effort of all involved has achieved a significant level of preventive, promotive and curative health care to the 0-6 years old in the Philippines.

Programme Strategy

Baguio's Under-Six Clinic (BGHMC), as the core of the programme has developed, tested, and evaluated a systematic approach to the clinic's activities in the past 10 years. Modules were designed to be used as guides for the duplication and implementation of the programme in all regions. The programme is directed towards the development of a training programme for health personnel (trainors and implementors) non-government organizations (NGOs) to replicate the Under-Six Clinic activities in all hospitals, rural health units and barangay health stations all over the Philippines. Integrate in the primary health care the concept and implementation of the Under-Six Clinic and to generate more research studies for evaluation of the progamme leading to the development of better techniques for better child care.

Open Forum

STRENGTHENING MATERNAL AND CHILD HEALTH

Sound figures based on a thorough monitoring of all health indicators should be generated. This was stressed by reactor Dr. Sylvia Carnero of the Philipine Obstetrical and Gynecological Society who said that health ministry (MOH) statistics are just "not believable". Most hospitals she said, submit incomplete data or do not submit at all.

Dr. Pratima Kale, UNICEF representative to the Philippines said that based on her visits around the country, many areas which are not reached by health personnel are just "written off" and are not included in statistical data.

She noted that the idea of the hospital-based Under-Six program is very important, "but that is only one strategy because there are many, many mothers who are not even reaching the hospitals." In fact, most babies in the Philippines are delivered at home by trained or untrained "hilots" (traditional birth attendants). Health services should reach all areas as this would prevent the effective immunization of all children.

Reacting to the charge that mothers in most hospitals are not encouraged to breastfeed, Dr. Simona Alikpala of the Philippine Pediatrics Society said that it is also the mothers themselves who are hard to convince. Many have fixed biases about breastfeeding. Another hindrance, she said, is that about 95 % of mothers are working and are usually given, at most, sixty days maternity leave, not enough time to breastfeed their child.

Sr. Mary Pilar Verzosa of BUNSO, (National Coalition for the Promotion of Breastfeeding and Child Care), suggested that doctors, being the most credible members of the health sector, should give stronger statements on breastfeeding and try to restructure hospital policies.

It is also possible to work and to breastfeed at the same time. Motivation is the key. This was disclosed by Connie Estrada-Calimon, herself a working mother and a member of Gabay at Kalinga ng mga Ina (GKI), a support group for breastfeeding. She said that obstetricians should make mothers aware of breastfeeding support groups they can call if they have any questions.

All that is really needed to strengthen maternal and child health, is the spread of knowledge and information concluded Clavano. And she believes this can be done "if you saturate your population constantly, persistently, with health teaching."

CHAPTER 9

Rationalizing Health Manpower Production and Management

Fernando S. Sanchez, Jr.

Manpower is the most precious resource of a country. Manpower must be developed if the country is to develop at all. Health manpower development must be an integral part of health development and of national development. It must be planned.

Health planning in the Philippines suffers from the obvious omission of manpower planning. At least, officially it does not exist. We have not defined what kind and how many doctors, nurses, dentists, and other health workers we need now and in the future. There is little coordination, if any, between the producers of manpower (the schools), the regulators of the manpower (the Professional Regulation Comission) and the consumers (the community and the Ministry of Health). Each does not pay attention to what the others are saying and doing.

Health Manpower Planning involves:

1. forecasting the numbers and qualification of the manpower.
2. designing the manpower production.
3. determining the productivity and utilization.

4. determining and securing the financial resources.

5. defining intrasectoral and intersectoral relationships.

The Health Manpower Process include the determination of the requirement for manpower (both quality and quantity), the production of the manpower (education and training), and the retention and utilization of the manpower (health manpower management).

HM Requirement ------ HM Production ------ HM Management

HISTORY OF HEALTH MANPOWER PRODUCTION

The evolution and development of the manpower process in the Philippines of the different health personnel follow very similar patterns; they are, however, at different stages of development today. The state (in a simple statement that we all can understand) that health manpower production and management is in today is a MESS. By in a mess is meant: there are many graduates who are incompetent, there are many who are unemployed and under-employed, and yet our people are underserved.

This situation started with Pharmacy, followed by Nursing and then by Medicine. But we never learned. Dentistry is right behind Medicine in the mess, and Medical Technology and Midwifery are expected to follow into this mess if they are not yet in.

Higher education is mainly in the hands of the private sector who mostly treat education as business for profit. The products or graduates of the system are looked at by the nation, the government and the schools themselves as commodities or goods. And we allow the production to be principally dictated by the law of supply and demand without scientific analysis and projections. Worse, it is the supply and demand of foreign countries and not our own needs. Admittedly, there are many similarities between human products and non-human products, but we cannot stock human resources for future use; neither can we easily transport and distribute them to the rural areas where and when they are needed.

What happened in health manpower production can be gleaned from the available statistics on the number of graduates or registered professionals and the number of schools offering the courses. A summary of the events follows:

Pharmacy

Before the World War II and immediately after, pharmacy practice was lucrative. A graduate could rapidly put up his/her drugstore and could support a family. The pharmacy course was therefore a favorite choice for many young people then – and most universities in Manila and a few in the other regions put up colleges of pharmacy.

In the 1950s pharmacy began to lose it attractiveness to students. Frist, it became very expensive to put up a drugstore. Then it became less profitable. Finally, pharmacists are no longer needed in drugstores, only sales girls.

The pharmacy course had been adjusted so that the graduates can work not only in the pharmacies of the Ministry of Health and private hospitals where they are now but also in industries.

At the start of this decade, there were only fourteen schools in the Philippines offering pharmacy courses, six in Metro Manila, four in Region VII, the rest were in Region I, VI, and IX. From 1977 to 1981 the average number of pharmacists who passed the board examination was 497.

Nursing

Unlike the pharmacists whose opportunities for work are confined to their own country, the nurses find employment overseas particularly in the U.S.A. The opportunities for the nurses to work and even get permanent residence in the U.S.A. before 1980 is equalled only by those of the physician. Taking nursing is a passport to the U.S.A. so that thousands of young women flocked to nursing schools. Business was so good for nursing education that many hospitals put up schools of nursing. May exploited the students not only by receiving their tuition and other school charges, but charging exorbitantly for dormitory and board and using them as cheap labor.

After WWII there were only 17 nursing schools. This went up to 30 in 1960. By 1974, there were 88 which increased to 130 in 1980. The number of successful examinees in 1974 alone was 5,582 compared to only 1,965 from 1941 to 1956 and 8,508 from 1951 to 1960. A peak of 14,112 was reached in 1978 and over 13,000 in 1978 and 1980.

The U.S.A. closed her door temporarily to nurses in the late 70's. Many nurses could not find jobs and nursing lost its attraction. In 1980,

there was very insufficient number of applicants to nursing schools, which was reflected in the number who registered with the PRC in 1983 – 3,853, more than 10,000 less than in 1978. To survive, schools had open admission, meaning removed all restrictions so they could have students.

The quality of nursing education went down. To remedy the situation, they abolished the 3-year training program in General Nursing and required the 4-year leading to Bachelor of Science in Nursing.

Medicine

Before 1950 there were three medical schools in the country, 2 of which were private. Together, they produce less than 1,000 graduates yearly. The number of graduates annually increased during the period 1951-1960, to about 1,500 as four new schools opened and the number of students admitted in each school also increased.

The number of graduates decreased during 1960's as the schools imposed upon themselves a quota for freshmen admission and a moratorium in opening new schools was set.

The moratorium was lifted in 1973 and in a span of 10 years, 20 new medical schools opened. The number of graduates increased to over 3,000 this year and we expect this to go up to four or five thousand unless something drastic is done or happens.

Before 1975, a large proportion of the graduates went aborad with at least half of them becoming residents of foreign countries. In 1980, about 45 % of Filipino doctors were practicing abroad. During the last 5-7 years the door to the U.S.A. for physicians has been closed. And today we have an abundance of doctors.

The opening of too many medical schools too fast has resulted in the lowering of the quality of medical education. Many of the new schools are hospital-based, lack academic atmosphere and are deficient in facilities and clinical materials. There are not enough qualified medical educators particularly for the basic sciences. And in order to survive, provincial schools accept poor students who otherwise would not have been admitted to medicine.

Dentistry

Like in medicine, from 1945 to 1950, one to two dental schools opened yearly so that by 1950 there were 8 dental schools in the country of which only one was government. One of the schools eventually closed while no new school opened between 1951 and 1979. The annual number of dentists graduated before 1980 averaged less than 500.

From 1981 to 1985, the new dental schools opened because there was a demand probably due to population increase rather than because of opportunities in other countries. Less than 15% of dentists have left the country. Most of these schools are now in trouble because they bought equipment on loan to set up their programs. With the peso devaluation and the relatively low tuition fees they charge, they are hard put in making their payments, which are in dollars.

As with medical schools, there is a shortage of qualified faculty members. They also have problems in obtaining supplies for school operation, which are mostly imported.

Medical Technology

In 1977-78 there were 26 schools offering medical technology courses. Eleven were in the National Capital Region, 6 in Region I and 4 in Region VII. Together they produced about 1,500 graduates yearly before 1980 and about 2,000 between 1981 and 1985.

Medical technologiest worked principally in government and private hospitals. The demand for their services will not increase in the near future as there is no expansion of hospitals expected. There is no opportunity for them abroad except in the Middle East which is not very much.

Midwifery

Midwives constitute a large segment of the health personnel sector. In 1980, there were over 50,000 midwives according to the PRC records. The yearly production of the now more than 80 schools is over 4,000. In 1970, there only 57 schools producing about half of this.

Before 1952, midwifery training was only a one-year course. This was made 1 1/2 year in 1953 and extended to 2 years in 1975.

Other Health Personnel

Private schools also contribute significantly to the production of Nutritionists and Dieticians as well as X-ray technologists. The production of sanitary engineers and inspectors and of barangay health workers is principally carried out by government institutions and agencies.

In 1975, 1,244 registered with PRC as nutritionists and dieticians. This number went up to 2,711 in 1981. The number of schools offering Bachelor of Science in Food and Nutrition in 1978 was 32. X-ray courses were offered by 10 schools in the same year (1978).

PROBLEMS OF HEALTH MANPOWER PRODUCTION AND MANAGEMENT

Dimensions

For its population, the country has too many health sciences schools and is producing more doctors, nurses, dentists and other health workers than it needs. However, there are not enough health professionals available to meet local needs except in Metro Manila and other urban centers.

A glut in nursing manpower already exists in the country. If the present trend in production of other health manpower continues, the same will happen in these professions at the end of the century, or probably sooner as migration to other countries slackens.

The consequences of the "overproduction" of health manpower are:

1. Inadequate opportunities for postgraduate training. The country has not developed adequate postgraduate training programs for the health profession, having depended on foreign countries for this: With the virtual closure of the U.S.A. for postgraduate training, only a small proportion of Filipino doctors, nurses and dentists are able to pursue specialization studies. Particularly for doctors, unless graduate and postgraduate medical training institutions are developed, the specialist manpower needs of the future shall not be met and Philippine medicine will suffer.

2. Unemployment and underemployment. More than 10,000 nurses in the country are without work; many are engaged in occu-

pations other than nursing. Physicians and dentists who can practice privately are not affected much by lack of employment. However, in Manila where there are more than enough doctors, their services are under-utilized.

As is universally true, there is concentration of health professionals, particularly those who are well-trained, in the cities and urban areas. The health care of people in many rural areas are left to the paramedical personnel. Close to two hundred municipalities in the country are without doctors, more are without dentists. District hospitals are understaffed and many Rural Health Units are without doctors. And Provincial Hospitals lack specialists.

While many are hopeful that the glut of health professionals in the cities would lead to their spillage to the countrysides, it is doubted by others that this would correct health manpower maldistribution. Such an important problem should not be left to chance. Planned and concerted effort must be exerted in this dimension of the problem.

There are indications that health sciences education is deteriorating in quality. Failure rates in the professional licensing examinations are going up. The same is true of the performance in international examinations. The rapid opening of too many schools in a short time has aggravated the quality of education which had been criticized as irrelevant and sub-standard even in the past.

Health sciences schools in general are characerized as:

1. lacking in academic atmosphere being principally hospital-based.

2. having western curricula that are not applicable to local situation, too hospital-oriented and content-based.

3. having insufficient qualified faculty especially in the basic sciences.

4. having inadequate clinical materials.

The health of the people depends on, among others, the health services they receive. The implementation of Primary Health Care and the delivery of other health care services in the country is compromised by the many problems of manpower production. Overproduct-

ion and unemployment of health professionals, lack of manpower in rural and depressed areas, and substandard and irrelevant education are obstacles to the attainment of health for all.

Causes

The health manpower production and management problems can be traced to two very important causes. First is the lack of clear policies on health manpower development and coherent health manpower planning. Second is the tremendous economic difficulties the country is facing.

A. Incoherent Health Manpower System

There is total absence of a sensible policy on health manpower in the country. The only policy is freedom of movement. The health professionals have so much freedom and privileges without corresponding, or with so little responsibility toward the community and its members. There is little regulation of manpower production and management. Everything is laissez faire.

The National Economic Development Authority, the Ministry of Health and the Ministry of Education have their own planning offices and manpower plans, but they do not coordinate their work much less involve the private sector.

The result is too many health sciences schools offering undergraduate courses and too many graduates with little opportunities for further studies or employment in the country, leading to emigration to other countries and maldistribution of health manpower.

B. Economic Difficulties

Paradoxically, the Philippines is a country rich in natural resources but inhabited by poor people. Education, especially in the health field is a passport to better life and/or to greener pastures in other countries like the U.S.A.

The demand for training in the health sciences is exploited by proprietary schools and businessmen. Sub-standard schools produce incompetent graduates who cannot find adequate employment or are under-utilized.

The worldwide economic crisis has markedly affected the Philippines. Many industries have closed down or are closing. Unemployement rates have gone beyond 30! The government's foreign debts have reached 30 billion dollars. The balance of trade is negative. Unofficially, the government encourages the graduates to seek overseas employment to bring in dollars into the country and to ease the unemployment problems. The graduates are only too willing to do so in order to recover the big investment they put into their education.

The emigration to other countries exacerbates the maldistribution problem. With the deteriorating peace and order situation in the rural areas and little opportunity for professional growth and material improvement, it provides the graduates a better chance to improve their lot. Ironically, the Philippines, a poor country, invests much in the education and training of these graduates who serve the needs of the rich countries who do not invest anything on them. Further, the country is left with the less competent graduates who are not acceptable to the foreign countries.

The economic difficulties have forced government and the private sector to implement cost containment measures. The government has cut its health budget drastically and frozen hiring of personnel. Private industries do not fill up vacancies for doctors, nurses and dentists in violation of the Labor Code. Thus, the demand for health manpower is further reduced.

PLANNING HEALTH MANPOWER PRODUCTION AND MANAGEMENT

The planning of health manpower development must be taken in the context of the entire health planning and should include not only the production but also the management of health personnel.

Production

The quantity and quality of health personnel to be developed should be determined on the basis of future needs for their services. Therefore the following must be established:

1. Forecast of health needs considering future demographic picture, disease patterns, socio-economic development, and government-people relationship.

2. Characteristics of the community – the culture, mores, traditions, practices, level of education, level of development.

3. Services to be delivered at every level of the health care delivery system.

The training of the health personnel must be for the tasks that they are going to perform which in turn depend on the health services to be provided. The services for the various levels of health care delivery in the Philippines could be as follows:

1. Barangay Level:

   a. health and nutrition education
   b. environmental sanitation-water supply, waste disposal, chemical pollution
   c. maternal and child health-prenatal, natal (delivery of normal cases) and postnatal care, family planning, well child care.
   d. control of endemic diseases
   e. immunization
   f. treatment of simple cases including first aid
   g. provision of drugs
   h. screening andidentifcation if illnesses, referral to appropriate agency, and follow up of cases who are still under treatment

A team of village health workers are needed for these tasks and require technical assistance from experts who should be easily accessible.

2. Small towns

All of these in No. 1 plus services for:

   a. more serious cases not requiring hospitalization
   b. minor surgery
   c. first aid for more serious cases including immobilization for simple fractures
   d. abnormal deliveries requiring forcep extraction, breach extraction; delivery of twins, completion of abortion; care of premature baby
   e. blood typing, matching and transfusion
   f. visual refraction
   g. family planning providing the more difficult process

h. mental health
i. dental services
j. physical fitness

A health center is essential with a team of doctors, nurses and dentist. Facilities for chest X-ray, routine laboratory, blood chemistry and electrocardiographic services)(ECS).

3. Big Towns or Several Small Towns – district level

All of those in No. 2 plus services for:

a. more serious cases requiring acute or short term care
b. moderate surgery – e.g. tonsillectomy, uncomplicated appendectomy
c. caesarean section

A small hospital with some specialists is essential.

4. Provincial Level

All of those in No. 3 plus services for:

a. cases requiring major surgery
b. cases of chronic and degenerative diseases requiring sophisticated care including rehabilitation.

A complete hospital providing secondary and tertiary care is needed. Support for the traditional public health activities should be available as well.

5. National Level

Institutions at the national level should exist only for research and for the most sophisticated medical procedures such as transplant surgery.

The training of the specific health personnel will now depend on the skills, knowledge and attitudes required for the tasks to deliver the service.

List of Knowledge and Skills for Barangay Health Worker by Tasks:

1. Health and Nutrition Education

   - Communication skills
   - Knowledge: Health and practices
     Simple Nutrition

2. Maternal and Child Health

   - prenatal care: progress of pregnancy, signs os abnormalities, nutrition
   - attendance of delivery – skills and knowledge
   - well child care: breastfeeding, weaning and introduction of solids, identify if child is normal
   - immunization

3. Screening of Health and Referral

   - recognition of manifestation of desease
   - use of thermometer, sphygmomanometer
   - referral to appropriate agency

4. Treatment of Simple Cases and Provision of Drugs

   - Knowledge of simple essential drugs
   - symptomatic treatment: cough, fever, pains, headache, diarrhea, etc.
   - identification of emergency/danger signals and provide first aid and immediaete referral.

5. Follow-up

   - family planning – use of easy methods
   - follow up of recovered cases needing further treatment

6. Evironmental Sanitation

   - knowledge of importance of potable water and household methods of purification
   - skill in construction of sanitary toilets
   - knowledge of acceptable housing

7. Control of Endemic Diseases

   - Awareness of agencies/technical people from whom assistance can be obtained

For the higher levels of health services delivery, different types of professional health personnel shall be needed. The training of these personnel should be competency-based and community-based/oriented.

The following are some suggestions for the achievement of the desired result of the educational process:

1. Academic Excellence

   a. Development of Competence

      - Define tasks of the specific PHC personnel and the conditions under which the tasks shall be performed.
      - Provide learning activities under very similar conditions if not in actual place of work.

   b. Development of Self-Learning Skill

      - Use of problem solving exercises or problem-based learning
      - Learning by doing

2. Relevance

   a. To Community Needs

      - community-based/oriented program; content must be based on actual community situation

   b. To Health Care Delivery System

      - Content must

        1) have a balance of preventive, curative and rehabilitative activities
        2) emphasize team work
        3) include system of administration, linkages with other sectors, sociology and economics

c. Technological Advances

- Content must include latest technology

3. Development of Disirable Values

- Use of role models
- Exposure to community
- Assign trainee to work with a team
- Give trainee some responsibilities including leadership role
- Provide opportunity to participate in group learning, workshops, meetings, etc.
- Discuss reward system and career development

Management

If health manpower production in this country leaves much to be desired, HM management is even worse. Of course the concept HMM is relatively new, particularly in western countries and most countries are only beginning to be truly concerned with it.

It is now becoming universally accepted that management systems for health manpower should be installed in the health system for it to succeed in its goal to deliver necessary services especially in the rural areas and for the under-privileged. Just as HM production must be planned, deployment of health personnel must be determined according to needs.

The main components and basic elements of HMM that must be incorporated in the health system are enumerated below:

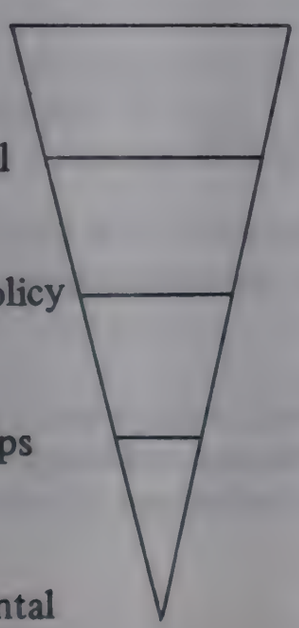
The Objectives of Health Manpower Management (WHO Health Manpower Management, 1983)

MAIN COMPONENTS	BASIC HMM ELEMENTS
Employing	Job Descriptions Establishment Control Recruitment Procedures Personnel Records Induction Distribution of Personnel and Utilization of Non-Professional Staff

Retaining	Career Structures Promotion Procedures Living and Working Conditions Job Security
Supporting	Supervision/Monitoring Communications and Consultation Collective Representation Continuing Education (Updating of Skills) Logistic Support
Developing	Performance Appraisal Continuing Education (New Skills)

Central to all management activities is the issue of motivation. This issue must be forced squarely because no management system will work unless the personnel are motivated. The strategy should be the enhancement of motivators and removal of demotivators.

Types and Examples of Motivation (WHO, Tashkent Consultation, 1985)



Types of Motivation	Examples of Motivation
Financial	Salaries, tax exemption, car, school fees, housing, state loans.
Professional	Promotion, specialty, contacts, university links, equipment, supplies.
National Policy	Posting on a compulsory basis, budget, provision for services.
Relationships	Personal suitability (e.g., health), support of superiors and staff.
Environmental climate	Respect and support from local commu-community.

Those motivators at the top of the pyramid will attract people – those at the bottom will persuade them to stay.

Some demotivators are:

A. Social – lack of
   1. good community and social life
   2. professionals to intereact with
   3. schools
   4. entertainment

B. Physiologic – lack of
   1. adequate housing with convenience, water supply, electricity
   2. hospital

C. Bad peace and order situations
D. Lack of employment for other members of the family
E. Lack of opportunity to move up/improvement
F. Improper training/over training

It is only fourteen years before the year 2000. If we are to achieve health for all Filipinos by that year, we have to act fast and now. Manpower production and management for health must be rationalized. We cannot allow the present system to go on.

RECOMMENDATIONS

1. Adopt a rational health manpower plan which will ensure production of health manpower who will be relevant and competent to serve the country's needs.

2. Develop and institute systems in health manpower management which will result in better deployment and utilizaiton of manpower. Stress the internalization of nationalist and altruistic orientations in future health workers.

3. Undertake a serious study in order to forecast future health manpower needs of the country. Based on the forecast, recommend a manpower production plan.

4. Effect a total moratorium on the opening of new schools of medicine, nursing and dentistry until the results of the aforementioned study are in.

5. For the existing schools, undertake an assessment to determine whether they come up to acceptable standards. At the same time, institute stricter policies on student admission.

6. For all state-supported health education institutions, adopt a policy of admitting only those students who will be willing to serve their country for a number of years after graduation whether in government or non-government organizations.

Open Forum

In the keynote speech, Dr. Buenaventura Angtuaco, member of the Professional Regulation Commission's Board of Medicine said that the "ravaged" health condition of the country stems from the maldistribution rather than the lack of health manpower.

"We have been opening new medical schools and paramedical schools without knowing how many people do we really ned to serve the future population of our country," said Angtuaco.

In his reaction, Dr. Sofronio San Juan of the UP College of Dentistry averred that there is also a maldistribution of dentists in the country. However, he said that the sexual composition of dentists, rather than the exodus abroad has spawned such maldistribution. He said that 70-75 percent of dental students are women and "we can't ask them to go to rural areas or do chores required from their male counterparts."

As is characteristic of the profit-orientation of most health science schools, Mary Vita Jackson, former Dean of the Pamantasan ng Lungsod ng Maynila, said that 90 percent of nursing schools are also motivated by profits. She also stressed the need for nurses to develop social awareness to make them more responsive to the plight of the less privileged.

Manifesto for People's Health

INTRODUCTION

Amid the euphoria following the February revolution, various sectors began to hold meetings to discuss what individuals and organizations could do in response to President Corazon Aquino's appeal for cooperation in the difficult task of national reconstruction.

Representatives from various non-governmental organizations, Metro Manila based but coordinating national networks of health groups, were among those that responded, medical style, to the new "emergency". An ad-hoc Steering Committee for a Task Force People's Health was formed to initiate, within three months, a series of weekly consultation workshops on vital issues in health care. These workshops started on March 18 and ended on May 21, featuring speakers on various topics starting with an overview of the health situation, and extending through topics such as the situation of health workers, drug policies, occupational health and safety, maternal and child care, primary health care, health manpower development and health financing. Following the delivery of each paper, reactors presented their views, followed by an open forum and discussion of specific recommendations on the topic discussed.

By early May, a clear trend had emerged as to the sentiments of the public, each workshop being attended by an average of 70 people representing health service agencies, hospitals, academic and research

institutions, consumer groups, the drug industry, labor unions, media and the lay public. The Steering Committee then drew up a draft for a Manifesto for People's Health, which was presented at a special workshop held on May 24, attended by sectoral representatives involved in health care and delivery.

The final Manifesto was ratified on May 28, with more than 150 charter signatories, culminating the first phase of activities of the Task Force People's Health. Responses to the Manifesto were delivered by representatives from the government and the private sector.

Logically, the next step is to translate the Manifesto into a program for action. At the May 28 meeting, participants gave the Steering Committee the mandate to create an organizational structure to disseminate the Manifesto for further discussion and to lobby for the implementation of the recommendations. Copies of the Manifesto have been forwarded to various government ministries and to local and international health organizations for further discussion. Additional signatures are also being gathered as part of the educational campaign.

By July, the Steering Committee hopes to expand its membership, which will draft a constitution and by-laws to be presented to a General Assembly. At the General Assembly, plans will be worked out to implement the many tasks and responsibilities that lie ahead. Numerous participants at the consultations have volunteered various services in support of the Task Force. The enthusiasm has been encouraging, a genuine manifestation of "people's power" gaining momentum to contribute in the building, not just of a better health care system, but of a more just society for the future generations of Filipinos.

PREAMBLE

We, health professional, workers, students, and citizens, having participated in the series of Health Policy Development Consultation meetings convened by the Task Force People's Health from March 19 to May 28, 1986 in Quezon City, Metro Manila, in response to the call of President Corazon C. Aquino for all sectors to become involved in national reconstruction efforts;

Deeply concerned about the underdevelopment of our country's health care system characterized by the maldistribution and inaccessibility of resources to the majority poor

especially those in the rural areas, and manifested by the preponderance of fatal and crippling communicable diseases, which are preventable and curable; malnutrition; high infant mortality rate; poor environmental sanitation;

Critically aware that the sad state of health of our people is the consequence of the interplay of soci-political, economic, and cultural factors such as graft and corruption, State neglect, lack of corporate social responsibility, foreign economic domination, professional elitism, and public apathy which became institutionalized during the Marcos regime;

Believing that all must become actively involved in the transformation of these social conditions which serve as stumbling blocks to the attainment of *Health for All Filipinos by 2000;*

SOLEMNLY DECLARE the following principles and recommendations to unify us in our collective efforts to improve our people's health:

DECLARATION OF PRINCIPLES

1. Health is a basic human right, just as the right to life is.

The Declaration of Alma Ata, of which the Philippines is one of 134 signatory States, strongly reaffirms that health – conceived of as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" – is a fundamental right and its attainment is a most important social goal.

2. The attainment and maintenance of health is the responsibility of the State and the people.

This entails the mobilization of all sectors of society. The control over the right to health and its corresponding responsibilities, must not be allowed to become the sole prerogative of particular entities – health professionals or the government, or commercial enterprise.

3. Nationalist economic and social development is essential for the health care system to be responsive to the needs of our country and people.

The interrelationship between health and development has been established. The purpose of development is to enable people to lead

economically productive and satisfying lives. This is only possible when the State exercises political commitment to ensure that the benefits of development reach the masses.

4. State policy in health must be guided by the principle of social justice and equity with a preferential allocation of resources toward promoting the health of the majority poor.

In the Philippine context, the State must marshall public resources and implement programs to achieve the greatest good for the greatest number. It must address the health care needs of the estimated 75 percent of our population living below poverty line, who have the least access to health services.

The State's commitment to the people's welfare is concretely expressed only when it places health services as one of its highest priorities in its overall development plan and budget allocations.

5. It is the State's responsibility to initiate, encourage and sustain inter sectoral efforts toward the achievement of "Health for All.

This can be achieved through its legislative, judiciary and law enforcement agencies. In the past, the State used health to advance political and economic interests of a few. Genuine community participation in decision-making processes and social mobilizations essential in the building of a responsive health care system were discouraged. This orientation must be reversed.

6. Service has been and should continue to be the guiding principle in the health care system.

Health professionals and workers are ethically bound to the promotion of health, prevention of disease and the preservation of life regardless of sex, class, race, creed or ideology. Such ideals must transcend rhetorics and be manifested in practice.

7. Health professionals and workers as members of society and citizens of the land should recognize the social and political dimensions of health and illness.

Health is a social phenomenon, determined not just by individual circumstance or action, but also by intertwining economic, socio-political and cultural factors. Health professionals and workers must therefore actively participate in the efforts directed to meaningful social change.

8. Efforts of non-governmental organizations (NGOs) in health development must be appreciated and harnessed by the State.

The non-government sector refers to private organizations which do not function as profit-making entities. They have pioneered alternative approaches to health care. Government can learn much from their experiences. But they must be allowed to retain their independence while working in partnership with the State and other sectors.

NGOs, however, must redefine their roles, and move away from "charity" dole-out approaches toward the promotion of greater community participation and self-reliance.

9. The private or business sector's interest in health must interface with public accountability, governed by ~~ehtical~~ codes that ensure the welfare of the general public.

Corporate social responsibility is particularly important in an underdeveloped country like the Philippines where the majority of our people are poor.

The business sector's need to achieve a profit margin is legitimate, but profits must be kept reasonable to allow maximum accessibility to its goods and services. This principle is based on sound business sense; any firm that insists on overpricing will be priced out of the market. Similarly, monopolies and cartels should not be allowed as this works against the principle of fair market competition.

Health includes a variety of basic human needs to which the business sector can cater. But it must not create artificial demands for products and services which have no objective basis in terms of medical need or efficacy.

The business sector must assist the State and other sectors within the health care system in maintaining the highest standards of quality of its goods and services.

10. An enlightened and organized citizenry can best work for the realization of a nationalist health care system committed to the development of people's health.

People's power already demonstrated in our country can be applied in the solution of health problems. This means that people are

not mere passive recipients or consumers of health goods and services but are active participants in decision-making processes at all levels.

Health programs are best implemented collectively. The formation and strengthening of genuine people's organizations must therefore be encouraged in all sectors. These organizations must enjoy the right to mobilize on various issues affecting their health and quality of life, ranging from better housing, improved water and sewage facilities, to broader issues like equitable redistribution of resources and wealth.

GENERAL RECOMMENDATIONS

1. Enshrine health as a basic human right in the new Philippine Constitution.

2. The Ministry of Health's efforts at reorganization should stress measures directed toward insuring efficient, honest and dedicated public service.

3. The national government should give top priority to increasing the health budget to assure adequate health care services for our people.

4. Give full support to primary health care, as a whole approach, toward the development of vital policies and programs.

5. Draw up realistic health plans at all levels and disseminate these plans to guide both the private and public sectors in the formulation and implementation of specific programs and projects. Evolve mechanisms for directing and evaluating health programs.

6. Clearly define the role and contributions of public and private sectors in setting up and administering health services, training and research. Rationalize linkages within and between the sectors.

7. Reorient the education of health professionals toward a more holistic perspective of health and disease and to more appropriate approaches in the management of health problems.

8. Demonopolize health knowledge and skills through an intensification of the training of primary health care workers and the development of appropriate health education for the public.

9. Initiate steps toward national self-reliance in health, particularly by strengthening research and development programs oriented toward

local production of drugs, medical supplies and equipment. Health programs should likewise reduce dependence on foreign aid and dole-outs.

10. Institutionalize rational procurement and consumption of medical technology and pharmaceuticals as a step toward the more efficient use of resources.

11. Strengthen the promotive and preventive components of health care rather than the curative through the intensification of programs in health education, immunization, environmental sanitation, nutrition, family planning, maternal and child care.

12. Give due attention to the plight of health professionals and workers in terms of improving wage structures, working conditions and participation in decision-making processes.

13. Evolve viable health financing schemes to replace or supplement Medicare. Such strategies could involve public and private institutions, realistically formulated according to available economic resources.

14. Abolish or amend past decrees, laws and regulations that deter efforts to build a more responsive health care system and that hinder or even endanger the public's health (e.g. P.D. 169 requiring physicians and hospitals to report all gunshot wound cases to the military; inadequate provisions in the Occupational Health and Safety Code).Legislate important bills such as the Consumers' Safety Code and the Code to Regulate the Marketing of Infant Formula.

15. Promote vigorously the concept of health as a public good and public concern which can be achieved only through multisectoral efforts and democratic processes.

SPECIFIC RECOMMENDATIONS

1. Conduct a serious health manpower production and management study to have a comprehensive situationer of the status of health manpower in the country.

2. Review and rethink national policy concerning the exportation of skilled health manpower. Focus on how these resources could instead be utilized productively for our country's needs.

3. Increase the health budget to ensure that healthy care services will be provided by health manpower effectively and efficiently through better conditions of life and work.

4. Upgrade or give just, humane salary/wages to health workers. Apply salary increases for both paramedical and non-medical employees in government who are part of the health delivery system.

5. Stop exploitative practices in hospitals like the use of volunteer nurses and nursing students to serve as cheap labor pool since these practices violate their human rights.

6. Implement recommended staffing patterns and standards of nursing and health practice to ensure our people quality care.

7. Enforce legislations which protect health workers from occupational hazards and compensate them for illnesses acquired in the course of performing their work.

8. Institutionalize mechanisms for democratic consultations in health care institutions. Recognize the rights of health workers in government hospitals to organize associations or unions which can negotiate collectively for improvements in their work and life conditions.

The following specific recommendations refer to particular areas in health policy which were discussed in the Task Force People's Health consultation meetings conducted from March to May 1986.

On the Quality of Work Life Conditions of Health Workers

Rationalizing Drug Policies in the Philippines

1. Adopt a national essential drugs list.

2. Encourage the use of generic names and limit the registration of new brand names and "me too" preparations.

3. Strengthen national drug regulatory authorities to insure consumer protection.

4. Provide independent and objective information to health professionals and the general public on the rational use of drugs.

5. Initiate steps toward self-reliance in pharmaceutical needs.

Economics of Health Care

1. Identify and develop resources that can be maximized for local uses in health care.

2. Incorporate economics of health care in the curricula of medical, nursing and allied medical health schools.

3. Campaign among health policymakers, health professional organizations and practitioners in general on alternatives to bring down costs of health care.

4. Evaluate and review the effectiveness of existing health financing schemes such as Medicare, private health insurances, health maintenance organizations.

5. Encourage innovative schemes, including community-based health programs, wherein the state and the people can share responsibilities to develop programs that will effectively bring health care to people at minimal cost.

6. Educate the public on appropriate and judicious use of health care facilities and services in order to lower medical expenditures.

Hospitals in Crisis

1. Establish new hospital facilities strictly on the basis of a thorough study of the specific health needs of the targetted catchment areas.

2. Expand the role of hospitals beyond the curative. Systematize and institutionalize patient health education programs in all hospitals as a preventive and promotive measure.

3. Study the setting up of a government fund to subsidize charity emergency patients treated in private hospitals.

Ensuring Workers' Health and Safety

1. Impose the necessary penalties for violations of occupational health and safety standards.

2. Strictly enforce existing laws that protect workers' health and safety. Corollary to this, strengthen responsible government regulatory bodies.

3. Repeal and/or amend labor laws and policies that undermine workers' right to health.

4. Amend rule 1042 to increase workers' participation in joint management-worker health and safety committees.

5. For trade unions, make workers' health and safety a priority concern; deepen workers' understanding of their rights by expanding labor education to include occupational health and safety.

6. Take positve actions to promote and safeguard workers' health and safety such as:

a. incorporating pertinent provisions in collective bargaining agreements

b. initiating factory-based PHC programs.

c. organization of "workers only" health and safety committees.

7. Heighten the awareness of health professionals and students regarding occupational health, hazards and diseases. Promote among their ranks advocacy of worker's rights to a safe and healthy workplace.

Primary Health Care: Health in the Hands of the People

1. Make Primary Health Care the centerpoint for policy and program development in health. Utilize and strengthen Primary Health Care as a comprehensive and integral approach to guide policies on drugs, hospitals, health manpower development, health care financing, etc.

2. Launch a national review of Primary Health Care policies, plans and implementation, by creating a Task Force on Primary Health Care whose aim is to evaluate its present status and its implication to the National Development and Health Plans. Ensure substantial participation of non-government organizations in the Task Force.

Maternal and Child Health

1. Improve social and economic conditions as a prerequisite for more viable MCH programs.

2. Give greater budgetary priority to MCH.

3. Strengthen the provision of MCH services at the barangay level. Ensure the integration of family planning in MCH services.

4. Urge the MOH to update and release accurate statistics as a basis for prioritizing its programs.

5. Enact or implement laws to promote breastfeeding and better mother-child care. In particular, lengthen maternal leaves and upgrade benefits.

6. Strengthen education and information components of UNICEF's Child Survival Program.

7. Adopt the Code to Regulate Marketing of Infant Formulas.

8. Define the role of NGOs in MCH and firm up collaboration efforts with government.

9. Include health indicators especially those related to MCH, as a basis for evaluating the performance of government officials.

Rationalizing Health Manpower Production and Management

1. Adopt a rational health manpower plan which will ensure production of health manpower who will be relevant and competent to serve the country's needs.

2. Develop and institute systems in health manpower management which will result in better deployment and utilization of manpower. Stress the internalization of nationalist and altruistic orientations in future health workers.

3. Undertake a serious study in order to forecast future health manpower needs of the country. Based on the forecast, recommend a manpower production plan.

4. Effect a total moratorium on the opening of new schools of medicine, nursing and dentistry until the results of the aforementioned study are in.

5. For existing schools, undertake an assessment to determine whether they come up to acceptable standards. At the same time, institute stricter policies on student admission.

6. For all state-supported health education institutions, adopt a policy of admitting only those students who will be willing to serve their country for a number of years after graduation whether in government or non-government organizations.

We, the signatories to this manifesto, recognize the constraints faced by the new government. We offer our support and cooperation in working toward short - and long-term solutions to the existing crisis, with the hope that past mistakes will not be repeated, and that we can leave to the next generation of Filipinos a legacy that is relevant and realistic.

Done this 28th of May, 1986 in Quezon City.

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RESTORING HEALTH CARE TO THE HANDS OF THE PEOPLE

A book published early in 1987 by the Council for Primary Health Care had a title with a message: Caring Enough to Cure. That anthology diagnosed the "disease-poverty-syndrome". In this new compilation, BUKAS presents additional information on the health care system in the Philippines, the results of a series of snap symposia launched after the snap revolution of 1986. The culmination of the symposia was the ratification of a Manifesto for People's Health, a proposed agenda for long-overdue changes to make the health care system more relevant to people's needs. An introduction updates the figures and synthesizes the main points brought out in the papers to emphasize the need to recognize the relationship of health to development and democratic processes.

As the Philippines enters a new phase in its history, the need for concrete plans and action becomes more urgent. The recommendations presented in this book will have to be implemented through various means: legislation, community-based health programs, educational campaigns on specific issues. This book emphasizes the role of popular participation in all these activities, and is based on the assumption that health is a basic human right which can be achieved only when people realize that the achievement of health is also a responsibility that must involve the public and private sectors, health professionals and workers as well as the lay person. As we begin to restore health care to the hands of the people, new questions will emerge, posing greater challenges to all concerned sectors. If we do care enough to cure, then we must accept the imperative to act now.

BUKAS (Bukluran para sa Kalusugan ng Sambayanan or Task Force People's Health) was formally launched in May 1986. It is a non-governmental, non-profit organization which is engaged in advocacy work, including information, education and lobbying activities. Its members include physicians, nurses, dentists, pharmacists, other allied health professionals and community health workers.

Health Action Information Network (HAIN)
Price ₱45

ISBN 971-8508-02-3